



RIVERSIDE CHIROPRACTIC CO., LLC

Dr. Curtis Reynolds, D.C. • 2601 Manatee Ave W, Suite E • Bradenton, FL 34205

ASSIGNMENT OF INSURANCE BENEFITS & CONSENT FOR CHIROPRACTIC CARE

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City/State/ZIP: _____ Email: _____

1. ASSIGNMENT OF INSURANCE BENEFITS / DIRECTION TO PAY

I authorize and direct my health, automobile/PIP, medical-payments (MedPay), or other applicable insurance carrier(s) to pay directly to Riverside Chiropractic Co., LLC, for services provided to me, all insurance benefits otherwise payable to me for those services, to the extent permitted by my policy and applicable Florida law. I assign to the Provider my rights and benefits necessary to obtain payment for covered services rendered by the Provider, including the right to receive claim information and, where permitted by law, pursue payment of assigned benefits.

I authorize the Provider to submit claims and obtain from my insurer information reasonably necessary to process those claims. A copy of this assignment may be treated as valid as the original. This assignment is subject to the terms of my insurance policy and applicable law.

Primary Insurance: _____ Member/ID #: _____
Group #: _____ Policyholder: _____ Relationship: _____
Auto/PIP Carrier (if applicable): _____ Claim #: _____

2. FINANCIAL RESPONSIBILITY

I understand that insurance verification is a courtesy and is not a guarantee of payment. I remain financially responsible for charges not paid by insurance, including applicable deductibles, copayments, coinsurance, non-covered services, exclusions, and amounts denied or otherwise not payable under my plan, unless the Provider is contractually prohibited from billing me for such amounts. I agree to notify the office promptly of any change in insurance or personal information.

3. CONSENT FOR CHIROPRACTIC CARE

I request and consent to chiropractic examination, evaluation, and treatment recommended by Dr. Curtis Reynolds, D.C., and/or another appropriately licensed chiropractic physician treating me at Riverside Chiropractic Co., LLC. Care may include spinal or extremity adjustments/manipulation, therapeutic exercise, soft-tissue techniques, and other chiropractic procedures within the Provider's lawful scope of practice.

I understand that chiropractic care may involve temporary soreness, stiffness, discomfort, bruising, muscle or soft-tissue irritation, aggravation of symptoms, and other risks. Rare complications can include fracture, disc injury, nerve or other neurologic injury, or other adverse events. I understand that no specific result or cure has been promised or guaranteed.

I understand that reasonable alternatives may include no treatment, home care, exercise/rehabilitation, physical therapy, medication, medical evaluation, or other appropriate treatment. I have had the opportunity to ask questions and understand that I may discuss concerns, risks, benefits, and alternatives with the doctor before or during care.

I agree to provide complete and accurate information about my health history, medications, surgeries, pregnancy, osteoporosis or other bone-weakening conditions, neurological symptoms, and other conditions that may affect the safety or appropriateness of care.

4. AUTHORIZATION & SIGNATURE

Patient/Authorized Person Signature: _____ Date: _____
Printed Name: _____ Relationship (if not patient): _____
Parent/Guardian Signature (if applicable): _____ Date: _____
Witness Signature (optional): _____ Date: _____
Doctor/Provider: Dr. Curtis Reynolds, D.C. Date: _____

Patient copy available upon request. This form is intended for use with applicable insurance and Florida law; insurance plan terms control where applicable.