REQUIRED RELEASES/SIGNATURES

Records Release: I hereby authorize the release of any information by The Spinery Chiropractic to my insurance company, or immediate family on behalf of myself and/or dependence.

ASSIGNMENTS AND BENEFITS: I direct assignment of payment of medical benefits to The Spinery Chiropractic for services rendered to me and/or my dependence.

ALL COMMERCIAL INSURANCE including MEDICARE: I require that payment of authorize medical benefits, for any service performed by the physician/clinic/supervisor, be made to The Spinery Chiropractic on my behalf. I authorize any holder of medical information, needed to determine these benefits or the benefits payable for related services, be released to the healthcare finance and administration and its agents. I provide a copy of this authorization to be used in place of the original.

Date_____

Signed_____

COLLECTION POLICY: As a new patient to The Spinery Chiropractic you should be aware of our collection policy regarding outstanding bills: You are responsible to The Spinery Chiropractic for all charges incurred. We will submit claim forms to your insurance company and we do participate in most plans. You are responsible to know all the specific coverage details of your Health Care policy. Failure to pay a balance after processing insurance will result in your account being turned over to a collection agency. Should your account be determined by the collection agency to be uncollectible, your credit rating may be adversely affected. I understand this collection policy.

Date_____

Signed_____

ACKNOWLEDGE THE RECEIPT OF PRIVACY PRACTICES (HIPPA): I acknowledge that I was provided a copy of the notice of privacy practices and I have read or have been given the opportunity to read the notice and understand it.

Date_____

Signed_____

Parent/Authorized Representative (if applicable)

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