

Authorization Form and Financial Policy

Life Line Chiropractic

Please initial next to each statement, indicating that you give authorization.

Some statement may not apply to you specifically.

Release of Information

_____ I hereby authorize Life Line Chiropractic to release my medical and financial data to my insurance company and/or attorney.

Protected Health Information

_____ I give permission for Life Line Chiropractic to use my address, phone number, and clinical records in order to contact me with appointment reminders, notifications, birthday/holiday related cards, possible alternative treatment options, and/or health related information.

_____ I give permission to disclose protected health information in the presence of anyone accompanying me into a treatment room or consultation room by my request.

_____ I give permission to disclose protected health information to any other specialist, if deemed necessary in further treatment of my care. This is to include the release of my medical records, photo identification, and insurance information.

_____ I understand certain times treatment could be rendered in open room areas, where other patients are also being treated. I am aware other patients in the office may overhear some of my protected health information during the course of my care. Should I need to speak to the doctor and/or staff privately, the opportunity will be given for a private conversation.

_____ I give permission for Life Line Chiropractic to send, by mail or fax, any of my protected health information that is necessary for treatment, payment, and/or further services.

Responsibility of Bill

_____ I accept full financial responsibility for charges and services rendered to me as a patient.

_____ I understand that services are rendered and charged to the patient. Services are not charged to the insurance company, only billed to the insurance company. Life Line Chiropractic cannot accept total responsibility for collecting an insurance claim, nor negotiating a disputed settlement.

_____ I also agree that this obligation shall exist regardless of private contractual agreement between the myself and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance, for which payment is denied through any utilization review or precertification procedures. I also understand that if I suspend/terminate my care and treatment, the fees for services rendered to me will immediately be due. In the event of default I will pay legal interest on the indebtedness, along with collection costs and reasonable attorney fees that may be required for collection.

Subrogation and Rights of Reimbursement Agreement

_____ If I, or a covered dependent, receive benefits under my health insurance carrier, hereinafter referred to as carrier, due to an injury or illness as a result of the acts of a third party, I agree to repay the carrier any amount of money that I receive for third party of its insurer as compensation for such injuries up to the amount paid out by carrier. I understand that this includes the insurer, other agent, or if I enter into an form of settlement regarding an accident which I, or my covered dependents, are injured as a result of the acts of a third party. I will do whatever is reasonable needed to secure the carrier's rights and shall do nothing to damage such rights. I will abide by this agreement, only if my health insurance policy contains language that gives the carrier subrogation and rights of reimbursement.

Authorization for Payment of Insurance Benefits to Provider

_____ I authorize payment of the medical benefits, otherwise payable to me, to be made payable and mailed directly to Life Line Chiropractic for professional services rendered. No other third party, including attorney, should receive payment of my bill except this office for the remainder of this claim, unless denoted by a LOP for the attorney. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage, and will send payments directly to this office. If payment is not rendered within 90 days upon receipt of payment from any other sources, then your account will be considered in default. Defaulted accounts are turned over to a collection agency and/or attorney for nonpayment. All charges incurred will be added to your bill along with any postage, interest or filing fees.

_____ **Returned Check Fee-** I understand that the fee for any returned check for insufficient funds, closed accounts or any other ancillary concerns will be an additional \$35.00 charge. This fee will be required to be paid by credit card, money order, or cash.

_____ **X-rays-** I understand that there is a possibility of taking x-rays for my care. If the doctor feels that x-rays are necessary for a complete study and understanding of my condition, then I give permission.

_____ **Female Patients-** To the best of my knowledge, I am not pregnant.

I fully understand and accept the terms of this consent.

Patient Name

Date _____

Signature

You have the right to revoke parts of this authorization in writing at any time.