

**AUTHORIZATION, ASSIGNMENT & RELEASE FORM
AUTHORIZATION & ASSIGNMENT**

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and action in my name is you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit, However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due. I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Indiana.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effort until revoked by both parties.

Date

Patient/Insured Signature

RECORDS RELEASE

To _____, I hereby authorize you to release to _____ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from _____ to _____.

Date

Patient/Insured Signature

Date

Authorized provider representative

CONSENT FOR TREATMENT OF MINOR

I being the parent, guardian or custodian of _____ A minor, the age of _____, do hereby authorize, request and direct Dr. Harris to perform in his judgment any necessary examination, x-ray, and chiropractic treatment for the condition.

Date

Parent, guardian, custodian

Date

Witness

OFFICE FINANCIAL POLICY

CASH: All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

INSURANCE: If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with same, as your contact between you and your insurance company.

Whenever you receive any worksheets from your insurance company of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine if proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check-it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. Any services not covered or coverage reduction by your insurance will be the patient's responsibility. This office will resubmit a claim ONE TIME. We will not enter into a dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

If the patient is referred to another specialist or discontinues care for any reason other than discharged by the doctor, the bill is due and payments in full immediately regardless of any claims submitted.

DELINQUENT CHARGES: Should my account with Central Indiana Chiropractic become delinquent all reasonable cost associated with the collection of account will be added to the balance. This will include all court costs, filing fees, and attorney fees. Any check returned to Central Indiana Chiropractic for reason of Non Sufficient Funds must be claimed within 10 days and a \$20.00 service charge will be attached to the account and must be paid at the time check is picked up. NSF check must be paid in cash.

I agree to pay for services rendered to the above patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance company carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable. Full payment rendered for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor. Insurance cases: On all insurance assignments the deductible should be met in the beginning unless prior arrangements are made.

Patient or Guardian Signature

Date

Authorized provider representative

Date