The Pain Relief Center
Stephen Dohoney D.C., DAAPM

AUTHORIZATION AND ASSIGNMENT

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

✓ 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

✓ I authorize direct payment to you of any sum I now or hereafter owe to you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

✓ It must be understood that my insurance contract is between myself & my insurance carrier & there is no guarantee of insurance payment. The Pain Relief Center will make all efforts to obtain payment, but will not enter into dispute with the insurer. I am responsible for any & all unpaid or denied claims.

✓ In the event any insurance company, obligated by contractual agreement to make payment to me or to The Pain Relief Center for the charges made for their services, refused to make such payment upon demand by them, I hereby assign & transfer to them the cause of action that exists in my favor against any such company & authorize them to settle or compromise what said as they see fit. It is understood that until all reasonable efforts have been made to collect the sums due from the insurance company(s) obligated by contract, they will refrain to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance company, whether it is all or part of what is due, I personally owe to them.

✓ If The Pain Relief Center is in network with my insurance carrier, they will file my claims for me. State law requires all applicable deductibles & co-payments be collected at the time of service, unless other arrangements have been made. If The Pain Relief Center is not in network with my insurance carrier, or I am not eligible for chiropractic benefits under my insurance policy, a $45.00 payment is due at the time of each office visit, unless other arrangements have been made with the front desk staff. An itemized bill will be provided upon request.

OFFICE POLICY

✓ The treatment you receive has a specific frequency and duration that is known to be therapeutic for your condition. It is most important to keep all scheduled appointments and to be on time. Please notify us if you are unable to make any scheduled appointments. There will be no charge for any missed appointments.

PRIVACY NOTICE ACKNOWLEDGEMENT

✓ We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act of 1996* (HIPAA), we are required to supply a copy of our privacy policies and procedures. We have supplied a copy of this document on the front desk, as well as in the waiting room. We encourage you to read this document, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If desired, we will provide you with an individual copy upon request. If you have any question or concerns in this regard, we would be happy to address them.

I agree that I have read and understand the Authorization and Assignment as stated above. I acknowledge that I have read and understand The Pain Relief Center's Office Policy. I also acknowledge that a copy of Notice of Privacy Practices for Protected Health Information from The Pain Relief Center is available to me upon request.

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Print Patient's Name

_____ _____

Patient Signature **(or Parent/Guardian if under 18)** ***Date***

_____ _____

Witness by Staff Signature ***Date***

Revised & Edited on 11/6/2013