PREMIER CHIROPRACTIC + PERFORMANCE

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

Please read and sign the following:

1) I authorize this office to release or receive any information necessary for my medical file and to expedite insurance claims.
2) I hereby authorize this office to bill my insurance company directly or their services.
3) I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
4) In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgement, or insured payment by which I recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made with 60 days it is my responsibility to pay my doctor's bill directly. Further, I agree to pay PREMIER CHIROPRACTIC + PERFORMANCE the difference, if any, between the total amount of charges and the amount paid to me by the attorney and / or insurance carrier. I further understand and agree that if I have to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fees.

There will be a $30.00 charge on all returned checks.

A photostatic copy of these authorizations and agreements shall be as valid as the original.

If there is not insurance involved at this time I agree that these services will be on a cash pay basis.

Signature _____

Date _____

Witness _____

****Please present both your insurance card and your drivers license so we can make a copy for our records.****