Teasel Chiropractic Clinic
8865 Brecksville Rd, Ste 8, Brecksville, OH 44141
440.736.7444

Patient Name: _____ **Date:** _____

Authorization & Assignment

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

1. I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Teasel Chiropractic Clinic as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.
2. I hereby authorize payment of, and assign my rights to, and health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.
3. I hereby authorize the release of any health status, conditions, symptoms, or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.
4. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in writing. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.
5. I understand that this office will bill my insurance company for the appropriate fees for services rendered. I will be required to pay deductible and/or co-insurance payments if mandated by my insurance policy agreement. I hereby promise to pay my bill within ten (10) days from the date my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.
6. I understand that X-rays may be necessary for the diagnosis and treatment of my condition, and those X-rays, if needed, will be taken in this office. I understand that my X-rays will be sent to PROFESSIONAL IMAGING CONSULTANTS (PIC) for interpretation and written report by a board certified chiropractic radiologist. I understand that PIC will bill my insurance carrier, attorney, or the appropriate responsible party. I authorize that any payments from my insurance carrier or attorney be sent directly to PIC. A photocopy of this assignment shall be considered as valid and effective as the original.

Acknowledgement

I have read and fully understand the above statements. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____