Assignment of Benefits Form

Financial Responsibility

I have requested services from EDC Family Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. I understand that insurance coverage is a supplement to help pay for care, not a sole means of achieving it. Regardless of what my insurance policy says they will pay, all services/products rendered are my responsibility. I understand that payments paid are applied first to any products/care not covered by insurance then to any deductible, co-pays, etc. Balances greater than 90 days past due may be sent to collections and a collection agency fee (minimum of 50% of the balance) will be added to the balance due.

Authorization of Release Information

You, EDC Family Chiropractic, and Dr. Jeremy Book, are authorized by me to release any information you deem appropriate concerning my care to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred at EDC Family Chiropractic by me. I also request payment of government benefits either to myself or to the party who accepts assignment on the HFCA-1500 form used to file my insurance.

Assignment of Benefits

I authorize payment of medical benefits to the physician or supplier listed on the HFCA-1500 form used by EDC Family Chiropractic for services described on the said HFCA-1500 form.
I authorize and assign the direct payment to EDC Family Chiropractic of any sum I now or hereafter owe you by any insurance company obligated to reimburse me for the charges for your services. I give assignment and lien against any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.
Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Patient/Responsible Party Signature: _____ Date:_____

Witness: _____ Date: _____