



Assignment of Benefits

I hereby understand that the fees that are listed in this claim may not covered by or may indeed exceed all of my plan benefits. I also understand that I alone am financially responsible to the service provider for all of the above cost that is associated with this claim and I do hereby assign my benefits payable from this claim to the above-named service provider and I authorize payment directly to them. In the event that my insurance company sends the payment for my service directly to myself or the plan subscriber, I acknowledge that it is my financial responsibility to forward that payment to New Hope Chiropractic, Inc. Failure to forward any payment by my insurance company within a reasonable time frame may result in collections.

I fully understand that the Benefit plan Sponsor has the right to modify the assignment privileges for specific benefits, categories and/ or service provider categories.

I hereby certify that all of the information that is provided in connection with this claim is true, complete and accurate. I authorize any doctor, medical practitioner, or any other person that may have any records, knowledge or information regarding this claim to release such information and to exchange information with any of the named parties where the exchange is necessary for the proper procession of the claim.

HIPAA Privacy Disclosure

Our Privacy Pledge

While the law requires us to give you this disclosure, please understand that we will always protect the privacy of your health information.

Circumstances in which we may have to disclose your health care information:

- We may have to disclose your health information to another health care provider if it is necessary to refer you to them for testing or treatment.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment.
- We may need to use your health information within our practice for quality control or other operational purposes.

Your right to limit use or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, the restriction is binding on us if we do agree.

Your right to revoke your authorization

You may revoke your consent to us at any time in writing. We will not be able to honor your revocation if we have already released your health information before receiving your revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.