

ALL WAYS CHIROPRACTIC, PLLC
ASSIGNMENT OF BENEFITS & PATIENT FINANCIAL AGREEMENT

RELEASE OF INFORMATION: I authorize **All Ways Chiropractic** to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs, and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance owed by me and agree to make full payment upon receipt of the statement after insurance has met its obligation. I understand it is my responsibility to provide All Ways Chiropractic with all my insurance information. *If I fail to provide all my insurance information to All Ways Chiropractic for billing of services rendered in a timely manner according to my insurance companies billing guidelines, I will be responsible for all charges for services rendered.*

Please print your initials on the line next to your billing and payment case type.

- **TIME OF SERVICE (TOS):** Payment is expected and due at the time services are rendered. We accept cash, checks, Master Card, Visa, Discover, Care Credit, FSA (Flex Savings Account) cards, and HSA (Health Savings Account) cards.
- **HEALTH INSURANCE:** Co-payments are due at the time of service. Co-insurance and deductible are due upon insurance processing. I have provided All Ways Chiropractic with a copy of the front and back of ALL my health insurance cards. I understand that any quote of benefits from my insurance company does not guarantee coverage or insurance payment. All Ways Chiropractic is not responsible for any changes made to my insurance policy. It is my responsibility to know my insurance benefits. My insurance claims will be billed by an employee or billing company hired by All Ways Chiropractic. I understand and accept that I am ultimately responsible for my account, which could include deductibles, co-pays, co-ins, non-covered services and denied services.
- **PERSONAL INJURY:** I have provided All Ways Chiropractic with the name and phone numbers of ALL insurance companies involved in the settlement of my injury claim. This includes claim number(s), date of injury, ALL insured party's name (including third party name), and/or the name of your attorney, if represented. ***All Ways Chiropractic requires an attorney for all third-party claims.*** I accept that All Ways Chiropractic does not bill health insurance for personal injury claims, unless no other insurance is available. We reserve the right to file a lien at any time. I understand I am ultimately responsible for my account and all charges incurred within. **No Recovery:** If no settlement or judgement is received, or if the recovery is insufficient to cover all fees and costs, the patient is still personally responsible for paying the full balance owed to **All Ways Chiropractic, PLLC.**
- **LABOR & INDUSTRIES:** I understand I am responsible for reporting my injury to the Department of Labor Industries or to the self-insured company retained by my employer. If I am switching care from another physician, I understand that All Ways Chiropractic has the required transfer card available to me. If my claim is not accepted or services are not covered, I understand I am ultimately responsible for my account with All Ways Chiropractic and all charges incurred within.
- **MEDICARE:** I have provided a copy of my Medicare card and supplemental health card, if applicable to All Ways Chiropractic. As a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.
- **VETERANS AFFAIRS (VA):** An authorization if required for claim payment. I understand it is my responsibility to obtain this authorization either through my Community Care Provider or from the VA directly. I understand that without a valid authorization on file with the VA, my claims will NOT be paid.

Signature of Patient or Authorized Representative

Printed Name of Authorized Representative

Printed Name of Patient

Date