AGREEMENT AND AUTHORIZATION FORM

Patient Name and Address _____

_____

_____

In consideration of the Agreement of Goffstown Chiropractic Care, PLLC, to provide treatment and chiropractic services to the patient, the patient hereby acknowledges and agrees as follows:

RELEASE OF INFORMATION
I hereby authorize Goffstown Chiropractic Care, PLLC to release healthcare and financial data to my insurance carrier(s) and attorney(s). I also authorize Goffstown Chiropractic Care, PLLC or its chosen representative to contact me at my home or work by telephone, fax, text message or e-mail concerning appointment times and scheduling, diagnostic testing results, electronic invoicing and other information pertinent to my care at this office.

Initials _____

RESPONSIBILITY FOR PAYMENT FOR SERVICES
The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance carrier(s). Goffstown Chiropractic Care, PLLC cannot accept total responsibility for collecting an insurance claim or for negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney or third party payor not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or precertification procedures.

Initials _____

CONSENT FOR TREATMENT OF MINOR CHILD
Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by Goffstown Chiropractic Care, PLLC and performed by its technical staff. The undersigned states that he/she is the patient's parent or legal guardian.

Initials _____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER
I hereby irrevocably authorize payment of the chiropractic benefits otherwise payable to me to be made payable and mailed directly to Goffstown Chiropractic Care, PLLC for professional services rendered. NO OTHER THIRD PARTY, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges chiropractic coverage and will send payments directly to this office.

Initials _____

ASSIGNMENT OF PAYMENTS
I irrevocably assign to Goffstown Chiropractic Care, PLLC, the right to payment for chiropractic services provided to the patient by Goffstown Chiropractic Care, PLLC out of (i) any applicable medical payments coverage; and (ii) any monetary recovery from a legally liable party, whether by settlement or by verdict. In order to effectuate such assignment, I agree to sign any and all documents necessary to effectuate this assignment, including, without limitation, a letter to any attorney representing me in the form provided by Goffstown Chiropractic Care, PLLC.

Initials _____

SUBROGATION AND RIGHTS OF REIMBURSEMENT AGREEMENT
If I or one of my covered dependents receive benefits under my health insurance carrier, hereinafter referred to as Carrier, due to an injury or illness as a result of the acts of a third party, I agree to repay the Carrier any amount of money that I receive from third party or its insurer as compensation for such injuries up to the amount paid out by the Carrier. I understand that this includes the insurer or other agent or if I enter into any form of settlement regarding an accident which my covered dependents or I are injured as a result of the acts of a third party. I will do whatever is reasonably needed to secure the Carrier's rights and shall do nothing to damage such rights. I will abide by this agreement only if my health insurance policy contains language that gives the health insurance carrier subrogation and rights of reimbursement.

Initials _____

The undersigned agrees to execute any additional documents necessary to implement the foregoing provisions.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
This is to confirm that I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment, obtain payment from third party payors and conduct normal healthcare operations such as quality assessments and accreditation.

Initials _____

_____ _____ _____

Patient, Agent or Representative Signature **Relationship** **Date**