



AUTHORIZATION, ASSIGNMENT,
AND CONSENT TO TREAT

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

Medical Release

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me.

Assignment of Benefits

I authorize the direct payment to you of any sum I now owe you, by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign such company (the pertinent data below) and authorize you to prosecute such action either in my name or in your name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will understand that whatever amounts you do not collect from insurance proceeds, (whether it be all or part of what is due) I personally owe you. In the event the balance of my account is turned over to an attorney and/or collection agency for collection, I will be responsible for all attorney fees, interest, penalties, and court cost.

Authorization to Treat

I, the undersigned, hereby authorize Dixon Center of Chiropractic, Inc. (and whomever may be designated as assistants) to administer such examination and treatment as they deem necessary.

A photocopy of this assignment shall be valid and have the same effect as the original.

Date

Patient's Signature

Witness

HEALTH CARE INFORMATION AUTHORIZATION AND APPOINTMENT REMINDERS

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminder and information and to leave messages on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, 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 decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This authorization will expire seven years after the date on which you last received services from us. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient Name Printed

Authorized Provider Representative

Patient Signature

Date