McCartney Family Chiropractic and Wellness P.C.

1079 S. Baldwin Rd. * Orion Twp, MI 48360 * 248-391-1600 * Fax 248-391-1624

Authorization and Assignment

AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION: McCartney Family Chiropractic and Wellness P.C. are authorized to release and/or obtain any information they deem appropriate concerning my physical condition as a result of professional services rendered by them and hereby release them of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any monies due him on my account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim. There will be a 5.00 monthly late fee charged to my account for all past due balances.

MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

CONSENT TO CARE: I hereby authorize the doctor listed below and whomever he may designate as his assistants to administer Chiropractic care as he deems necessary.

BLUE CARE NETWORK, HAP, & HAP SENIOR PLUS: I understand that I am required by my insurance company to obtain a referral from my primary care physician, listing any and all services (provided the benefits are available) in order for ***McCartney Family Chiropractic and Wellness P.C.*** to be able to submit insurance claims on my behalf. I also understand that this referral does not guarantee payment for any services that I receive. Including but not limited to spinal manipulations, spinal x-rays, vitamins, spinal supports, supplies, traction or heat. If my insurance company does not cover any of the above mentioned services or supplies, I'm aware that I am responsible for any costs incurred. I'm authorizing this acknowledgement to stand for the duration of my care from this date forward.

INSURANCE BENEFIT VERIFICATION: I understand that McCartney Chiropractic has verified benefits with my insurance company and I have been told what was quoted to them. I understand that my insurance company does not guarantee payment. Each service is reviewed for my eligibility and the terms and conditions of my policy on the dates the services were rendered. McCartney Chiropractic can not be held responsible for incorrect information given by my insurance company or myself or for unknown changes to my policy.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at the ***McCartney Family Chiropractic and Wellness P.C.*** and that I have been advised that the doctor providing the services is willing to wait for payment of these services, provided that there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of a liability case.

I understand that if it's determined either:

A. that there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor; or to make other provisions for the protection of the interest of the doctor; or
B. if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney or

then payment of the services rendered by the doctor at the McCartney Family Chiropractic and Wellness P.C. will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

Dated the _____day of _____, 20_____

_____ _____

Patient's Signature Witness Signature

_____

Patient's Printed Name