

Lien and Assignment of Insurance Benefits

I(we), the undersigned patient and/or legal representative(s) of that patient, in consideration of the services rendered or to be rendered by you, Shepherd Chiropractic, hereby understand and agree to the following:

I am personally responsible for all bills incurred by me for services rendered by Shepherd Chiropractic. I understand that you may make claims to insurance companies and other third parties for reimbursement to changes on my behalf as a result of professional services rendered by you. I agree, however, that I remain personally liable for all amounts due to you, which are not paid by such insurance companies or other third parties.

In the event that any insurance company or third party is obligated by contractual agreement to make benefit payments to me or you, I hereby authorize and direct that such insurance companies or other third parties make direct payments to you for any amounts owed to the extent allowable under such contractual terms.

In the event that any insurance company or third party under contractual obligation to make benefit payments to me or you refuses to make such payments after demand is duly made, I hereby assign, transfer, and set over to you, free and clear of any other encumbrances, the right to bring demands, claims, and other causes of actions which exist in my favor, against any such insurance companies or third parties for the total amounts owed to you. I authorize you to prosecute such actions and to compromise, settle, or otherwise resolve such claims as you determine appropriate.

In the event that the treatment provided by you was necessitated as a result of the potential negligence of any entity, I hereby give a lien to you against the proceeds of any settlement, judgments, or verdicts which may be acquired against such entity or any other third party providing indemnification or compensation to such entity.

I hereby authorize and direct that any attorney who may now or hereafter represent me make direct payments to you for services rendered out of the proceeds of any such settlement, judgments, or verdicts.

You are authorized to release information concerning my condition and treatment to my insurance company and attorney for the purposes of processing claims for benefits and payment of services rendered to me.

I hereby state that a photocopy of this document shall be as valid and binding on all parties as the original and applies to all past and future records.

Consent for Use or Disclosure of Health Information

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes such as reminder cards, messages on your answering machine or voice-mail, or newsletters.

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, if we agree with your restrictions, the restriction is binding on us.

You may revoke any of your authorizations at any time; however, your revocation must be made in writing. 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. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

By signing below, I have read and agree to the terms of the information above.

Printed Name _____

Patient/Guardian Signature _____

Date: _____