ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE
AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Northwoods Family Chiropractic as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I herby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I here by authorize the release of any health status, conditions, symptoms, or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partial paid claims, or to pursue any other remedies necessary in connection with same.

I here by assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, an/or my family members as a result of service rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan of this document is to be considered a valid and as enforceable as the original.

Date:_____/_____/_____

X_____
(Patient signature)

_____
(Please print patient name)

X_____
(Signature of Guardian if applicable)

Financial Policy

Insurance Coverage

Welcome to Northwoods Family Chiropractic. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deducible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurance to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determination.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment on your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)
A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered
B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current b paying for each visit at the time services are rendered.

Health Insurance: (please initial)
C_____ I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

Returned Check/Insufficient Funds Policy

It is the policy of Northwoods Family Chiropractic to assess a $20.00 returned check/insufficient funds fee to patients who have a returned check due to insufficient funds/other reasons or insufficient funds when running a stored credit card on file. More than 2 repeat occurrences will result in the inability to pay in this manner.

_____ My initials here indicate that I understand the above return check policy.

I understand that all health services rendered to me and charged to me are my person financial responsibility. I understand and agree to the conditions of the policy.

_____ _____

Signature Date