# NOTICE OF PRIVACY PRACTICES & ASSIGNMENT OF BENEFITS

Name: ________________________________ D.O.B.____________________ Today's Date:______________

**Authorization for Xray and Release**: I declare to the best of my knowledge I am not pregnant, my child is not pregnant, nor are there any known complicating limitations which would forbid taking x-rays. I understand that in the event x-rays are taken and require additional over-read, they will be referred to a radiologist and I may incur an additional read fee.

**If you are pregnant or think you may be pregnant please initial here.* ___________

**Acknowledgment of Assignment of Benefits**: By signing below, I hereby assign benefits to be paid directly to Poss Chiropractic by my third-party payor, e.g. insurance company, attorneys, etc. Furthermore, I understand that Poss Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and I authorize Poss Chiropractic to release medical records and other information to third-party payors in order to process claims. Any amount authorized to be paid directly to Poss Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

**CMS1500 Health Insurance Claim Form**: By signing below I acknowledge and agree that the CMS1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of medical records or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

**Acknowledgement of Notice of Privacy Practices:** In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), updated September 23, 2013, this office is obliged to supply me with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of my personal health information and rights as a patient. By signing below I have acknowledged that I have been offered a copy of this document if requested.

**Consent of Communication and Healthcare Information Authorization:** At times this office may need to contact me with appointment reminders, information about treatment, or other health related information. By signing below I have authorized this office to contact me with these information and understand that I may be contacted by phone at home/work, mobile phone, e-mail, text message, or regular mail. Messages may be left on an answering machine/voicemail or with individuals answering my phone/home/work/mobile.

**Acknowledgement:** By signing below I acknowledge that I understand and agree with the policies and procedures outlined in this form, and I acknowledge and certify that all the information given to Poss Chiropractic in the INTAKE forms is true and accurate to the best of my knowledge.

Patient Signature: ______________________________________________

Parent/Guardian Signature: ____________________________________