

Fogarty

Chiropractic Life Clinic



LASTING PURPOSE

Kevin Fogarty, D.C., F.I.C.A. (Hon)

FINANCIAL RESPONSIBILITY

Lifetime Assignment and Instruction for Direct Payment to Doctor Private and Group Accident and Health Insurance Authorization to Release/Request Records

Patient name: _____ SSN: _____ Date of Birth: _____

I hereby instruct and direct _____ Insurance Company to pay benefits by check made out and mailed to:

**FOGARTY CHIROPRACTIC LIFE CLINIC
839 BARTON BLVD.
ROCKLEDGE, FL 32955**

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional service rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY TO FOGARTY CHIROPRACTIC LIFE CLINIC FOR PAYMENT OF PROFESSIONAL SERVICES RENDERED.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I assign to said clinic all rights patient has under any contract of insurance for collection of same.

This also certifies that the above named individual agrees to pay in full for all professional services rendered at the time they are performed, unless other arrangements are made in advance of the set appointment. The below named guarantor understands a \$25.00 returned check fee will be charged along with any appropriate collection or attorney's fee which may accrue upon collection of any outstanding balance.

Initials

RECORDS REQUEST

This is to certify that the above named patient authorizes full request of any records pertinent to the health care of same individual from but not inclusive of any insurance carrier, adjustor, attorney, hospital or other health care provider.

This also authorizes Fogarty Chiropractic Life Clinic to release records, upon receipt of the above named patient's signature, or on an emergency basis, to but not inclusive of, any insurance carrier, attorney, health care provider, hospital or immediate family member.

Initials

A photocopy of this assignment shall be considered as effective and valid as the original. This document is considered a living document and does not expire.

Privacy: The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the *Health Insurance Portability and Accountability Act* of 1996 ("HIPAA") A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party.

I have read and understand the foregoing. I have also received a copy of the HIPPA privacy statement and Fogarty Chiropractic Life Clinic's Fee Sheet.

Date _____

Patient/Policyholder _____

Date _____

Witness _____