



Assignment of Benefits, Payment Agreement and Missed Appointment Policy

PATIENT: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

THIS AGREEMENT is made and entered into by and between the above named PATIENT and PROVIDER. WHEREAS, PATIENT desires to receive services from this health care PROVIDER and therefore desires to assign certain rights and benefits to PROVIDER it is hereby agreed:

A. Patient assigns to PROVIDER any and all benefits payable by PATIENT'S insurance or health care plan(s) as a result of charges incurred by PATIENT for services rendered by this PROVIDER. PATIENT also assigns to PROVIDER any and all contractual rights PATIENT has against any insurance company, health care benefit plan, or any other party contractually liable to PATIENT for payment of health care costs incurred by PATIENT as a result of services rendered by this PROVIDER. This assignment of benefits and contractual rights relating to those benefits includes, but is not limited to the following described policies or plans. This agreement nullifies any agreement now or in the future for any third party (attorneys) other than provider to receive any payments for any insurance benefits including Personal Injury Protection or Med Pay for medical services provided and billed from this clinic. This is the financial agreement of this PATIENT and ACTIVE FAMILY CHIROPRACTIC to have directly sent to PROVIDER as addressed above.

B. PATIENT hereby directs all insurers and other persons responsible for PATIENT'S health care costs to make all payments for health care services rendered by this PROVIDER directly to PROVIDER.

C. PATIENT agrees that in the event PATIENT receives any check, draft, or other payment subject to this Agreement, such monies will be held in trust for PROVIDER. PATIENT will immediately deliver said check, draft, or payment to PROVIDER. PROVIDER agrees to apply the proceeds from said check, draft, or payments to PATIENT'S debt for services rendered. Any violation of this agreement will at PROVIDER'S election terminate PATIENT'S charge privileges with PROVIDER and brings any balance owed by PATIENT to PROVIDER immediately due and payable.

D. This assignment of benefits and contractual rights shall not exceed the total amount due PROVIDER or others as a result of service rendered by this PROVIDER. PATIENT agrees that payment for services rendered by PROVIDER is due upon receipt of said services and acceptance of PATIENT'S assignment of benefits is a convenience to PATIENT and that PROVIDER may revoke this assignment at any time.

E. In the event PROVIDER has assigned to any third party all or any part of the amount owed from PATIENT to PROVIDER. PROVIDER may, upon receipt of any payment pursuant to this agreement, transfer any such payment to the current holder of the debt, to be applied to PATIENT'S account.



F. PATIENT agrees to waive any applicable statute of limitation which may at any time interfere with PROVIDER'S right to collect for services rendered by PROVIDER to PATIENT.

G. PATIENT hereby authorizes this PROVIDER to release any permit the examination and /or copying of any of PATIENT'S medical records, x-rays, laboratory reports, and the results of all tests of any time or character to such persons as PROVIDER deems appropriate.

H. PROVIDER is authorized to submit a copy of this Assignment, or notice thereof, with the initial claim form(s) which PROVIDER submits to third party payer(s) as notice to the third party payer(s) of the assignment and other agreements contained herein. A copy of this document shall be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in PATIENT'S file and may be picked up by the patient at any time or will, upon request by the PATIENT, be mailed to a designated address.

I. IN the event that any section or provision of this Agreement is legally void, invalid, or unenforceable, all other sections and provisions of this Agreement shall remain in full force and effect.

J. The assignments and agreements contained in this document may not be revoked by PATIENT without the express consent of the PROVIDER.

K. Your chosen insurance company does not guarantee benefits until claim arrives; and at that time an Explanation of Benefits will be given by your chosen insurance company stating your exact benefits. Any billing to insurance that is not covered (paid) by your insurance company is as stated by your insurance company to be the responsibility of the PATIENT. Any balance owed is the patient's responsibility.

L. PATIENT UNDERSTANDS THAT PATIENT IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED BY PROVIDER. ANY LEGAL OR COLLECTION EXPENSES INCURRED BY THIS CLINIC TO COLLECT BALANCE OWED BY THE PATIENT WILL BE THE FINANCIAL RESPONSIBILITY OF THE PATIENT.

M. PATIENT UNDERSTANDS THAT MISSED/NO SHOW APPOINTMENTS WILL BE CHARGED TO THE PATIENT AT A COST OF \$35.00. REPEATED LAST MINUTE CANCELLATIONS WILL ALSO BE CHARGED \$35.00, AFTER THE SECOND OCCURRENCE.

Patient Signature _____ Date _____

Patient Printed Name _____

Witness _____ Date _____

Witness Printed Name _____