Health Insurance Policy

Most insurance policies do cover chiropractic care, but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for your deductibles as well as any unpaid balances in this office. We do our best to verify your insurance coverage, and will bill your insurance in a timely manner. If you would like us to bill your insurance, please bring us your insurance information on or before your second visit. Until we have the completed, necessary insurance information to verify chiropractic coverage, you will be required to pay for your care.

We ask that you pay your copayment or coinsurance at time of visit. We make our best effort to determine that amount prior to your visit, but may only be able to provide you with a close estimate of cost.

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

Assignment of Benefits:

To: Dr. Todd R Cramer and Eagle Cramer Chiropractic.

This assigned patient and/or responsible party in addition to continuing personal responsibility, and consideration of treatment rendered or to be rendered to the physician or facility named the following rights:

DEMAND FOR PAYMENT: By signing this form you are authorizing payment of medical benefits to be made directly to this office, and should any payments be made directly to for your care, you agree to send or bring those payments to this office upon receipt. By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim.

RELEASED INFORMATION: You are authorized to release and permit the examination of my medical records, x-rays, and radiology reports to each person (s) as the physician and/or facility deems appropriate.

ASSIGNMENT RIGHTS: You are assigned to exclusive, irrevocable right to any cause of action that exists in my favor against an insurance company for benefits to the extent of your bill for total services if such benefits are owed with the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receiver penalties, interest, court costs, or other legally compensable amounts owed by an insurance company. I, as the patient and/or facility is also assigned the exclusive irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and any information or supporting documentation concerning or touching upon the handling, calculation, processing or payment of any claims.

THIRD PARY LIABLITY: If patient(s) treats for injuries are that are the result of negligence of any third party, then patient(s) grant a lien against any recovery from such a third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

STATUE OF LIMITATIONS: Patient(s) waive the right to claim Statue of Limitations regarding claims for services rendered or to be rendered by the physician/facility named about, in addition to reasonable costs of collections, including attorney fees and court costs incurred.

In the event that any provision of this *agreement* is determined to be invalid or unenforceable, to all other provisions of the *agreement* shall remain enforceable

Acknowledgement of Privacy Notice

As of April 1, 2003, our office is implementing the requirements of the Health Insurance Portability and Accountability Act (HIPAA) which was passed by the federal legislature.

Your signature is necessary so that we may continue to treat you and submit your information for reimbursement. Please review the 'Privacy Notice' and indicate that you have reviewed this document by signing below.

"My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice."

A PHOTOCOPY OF THIS AGREEMENT SHALL SERVE AS ORIGINAL

Patient's Printed Name: _____

Patient / Guardian's Signature: _____ **Date:** _____