KATZ CHIROPRACTIC & REHABILITATION CLINIC

Assignment of Benefits

I hereby assign payment directly to Katz Chiropractic & Rehabilitation Clinic/ Front Range Digital Motion X-Ray, who represents this clinic to Payor Groups for the basic benefits, as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if this is a motor vehicle accident and the medical benefits are exhausted such that financial responsibility reverts to my health insurance. I am financially responsible for any applicable deductibles, co-insurance or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered. I will update billing information in writing to Katz Chiropractic & Rehabilitation/ Front Range Digital Motion X-Ray as soon as any changes occur in my insurance coverage or address.

Signature____________________________________**Date**_______________________________

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge **$50.00** for missed appointments. Your courtesy of a phone call will allow us to contact patients that are on our appointment waiting list. This charge is not covered by or billed to your insurance. If due, please pay it at the front desk before your next appointment. Your signature indicates that you understand our policy.

Signature____**Date**___________________________

Release of Information

I **do/do not** (please circle one) authorize_______________________________(physicians name) to release any of my medical records, x-rays, or reports to Katz Chiropractic and Rehabilitation Clinic for the purpose of obtaining medical information pertaining to my treatment.

Signature____**Date**____________________________

Authorization to Discuss PHI

If you would like your Personal Health Information (PHI) to be discussed or given to another person, please give the name of that person below and sign, giving us permission to discuss your PHI with them.

Name:____

Patient Signature____**Date**__________________