

Authorization and Release

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do or do not want to receive your medical records, please inform our office.

In exchange for any credit provided to me by Pinto Family Chiropractic for services rendered, I agree to provide information and forms regarding any potential source of fee payment, to assist in any way I can and:

- If I am responsible for payment of my account without the help of insurance I agree to abide by whatever agreement I set up with this office to keep my account current.
- I hereby assign to this office my rights to receive payments from my insurance company or from any negligent party responsible for my injury. Payments should be mailed to:

Pinto Family Chiropractic, PLC
5601 Richmond Rd., Suite 14
Williamsburg, VA 23188

If my policy prohibits assignment, then checks should be made payable to me and sent to the above address.

- I authorize the office to release any information to any insurance company, adjustor, or attorney that will assist in payment of a claim.
- I fully understand and agree that my insurance policy is an arrangement between myself and my insurance carrier. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.
- I understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable at the discretion of this office. I understand that interest is charged on overdue accounts at the annual rate of 18%.
- In the event that legal action becomes necessary to collect any money due this office, I agree to the entry of a judgment in the amount equivalent to the unpaid balance plus interest at the rate of 18%, plus attorney and collection fees.

I have read and understand the policies of this office regarding my Patient Health Information and Financial Responsibilities:

Patient name: _____ Date: _____

Patient or Guardian signature: _____

A photocopy of this form shall be valid as the original.