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**Authorization and Assignment of Insurance Benefits**

**Assignment**.

 I hereby grant a direct assignment to (office designation) , hereinafter referred to as “doctor”, for application and payment to my bill for chiropractic services under all of my rights and claims for reimbursement under any governmental or private insurance plan, including, but not limited to, Medicare, Medicaid, insurance policies, managed care arrangements, or any other third party similar payor arrangement, that provides coverage for my health care costs and for which payment may be available to cover the cost of chiropractic services provided to me. I understand that I maintain responsibility for obtaining any required referrals, preauthorization, or any other applicable insurance coverage requirements.

**Irrevocable**. I acknowledge and agree that this assignment of benefits and/or right to compensation for treatment shall not be rescinded or revoked by myself, my attorney or anyone who claims to represent me. (*Optional as it relates to specific accident)* I expressly direct that this assignment shall apply to medical payments coverage under any applicable insurance policy. Any applicable insurance carrier is directed to open a claim for “medical payments” coverage and authorized to make direct payments to the doctor with respect to an accident which occurred on . All payments under such coverage shall not be made payable to me or my legal representative unless authorized by my doctor.

**Responsibility for Payment**. I understand that I am responsible for all chiropractic charges submitted for services rendered to me and that this agreement is voluntarily made to provide my doctor with additional protection for payment. (*Optional: I understand that if I suspend or terminate care, any outstanding charges for professional services will be immediately due and payable.)* I further understand that payment by me is not contingent upon any settlement, judgment, or verdict which I may eventually obtain for payment of outstanding charges.

**Authorization**. I authorize the use of my signature on all insurance submissions and payments. In the event that any attorney, insurance company, or any other third party is obligated to make payment to me or to my provider, I hereby assign and transfer to my doctor any cause of action or other legal right(s) which may exist on my behalf and expressly authorize my doctor to litigate, compromise, settle or otherwise resolve such claim as the doctor exclusively deems appropriate.

**Release of Healthcare Information**. I hereby authorize my doctor to release healthcare information to any attorney, insurance company or any applicable third party which is necessary to facilitate payment under the terms of this agreement. I further authorize any such applicable party to release any information relevant to the processing of a claim for reimbursement directly to my provider or its authorized representative. Such information can include, but is not limited to, insurance contracts, plans, booklets, summaries or any other materials which I am legally entitled to receive.

**Medicare/Medicaid**. If applicable, I certify that any information provided by me or my representative in applying for Medicare/Medicaid payments is correct and that I authorize the release of any such information necessary to determine my eligibility under Medicare/Medicaid. I understand that I am responsible for any deductibles, co-payments, co-insurance, and any expenses or charges not covered by such governmental payor.

**Photocopies**. A photocopy of this assignment/agreement shall be considered as valid as the original. A photocopy of any insurance claim(s) shall also be valid and have the same effect as the original.

Date:

 Patient/Authorized Representative

 Relationship to Patient (if minor/incompetent)

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