



# Lavan Family Chiropractic, LLC

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## AGREEMENT AND AUTHORIZATION FORM

In consideration of the Agreement of Lavan Family Chiropractic, LLC, to provide treatment and chiropractic services to the patient, the patient hereby acknowledges and agrees as follows:

### \_\_\_\_ **RELEASE OF INFORMATION**

I hereby authorize Lavan Family Chiropractic, LLC to release healthcare and financial data to my insurance carrier(s) and attorney(s). I also authorize Lavan Family Chiropractic, LLC or his chosen representative to contact me at my home or work by telephone, fax or e-mail concerning appointment times, diagnostic testing results and other information pertinent to my care at this office.

### \_\_\_\_ **RESPONSIBILITY FOR PAYMENT FOR SERVICES**

The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance carrier(s). Lavan Family Chiropractic, LLC cannot accept total responsibility for collecting an insurance claim or for negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney or third party payor not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or precertification procedures.

### \_\_\_\_ **CONSENT FOR TREATMENT OF MINOR CHILD**

Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by Lavan Family Chiropractic, LLC and performed by its technical staff. The undersigned states that he/she is the patient's parent or legal guardian.

### \_\_\_\_ **AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER**

I hereby irrevocably authorize payment of the chiropractic benefits otherwise payable to me to be made payable and mailed directly to Lavan Family Chiropractic, LLC for professional services rendered. **NO OTHER THIRD PARTY**, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges chiropractic coverage and will send payments directly to this office.

### \_\_\_\_ **ASSIGNMENT OF PAYMENTS**

I irrevocably assign to Lavan Family Chiropractic, LLC, the right to payment for chiropractic services provided to the patient by Lavan Family Chiropractic, LLC out of (i) any applicable medical payments coverage; and (ii) any monetary recovery from a legally liable party, whether by settlement or by verdict. In order to effectuate such assignment, I agree to sign any and all documents necessary to effectuate this assignment, including, without limitation, a letter to any attorney representing me in the form provided by Lavan Family Chiropractic, LLC.

### \_\_\_\_ **SUBROGATION AND RIGHTS OF REIMBURSEMENT AGREEMENT**

If I or one of my covered dependents receive benefits under my health insurance carrier, hereinafter referred to as Carrier, due to an injury or illness as a result of the acts of a third party, I agree to repay the Carrier any amount of money that I receive from third party or its insurer as compensation for such injuries up to the amount paid out by the Carrier. I understand that this includes the insurer or other agent or if I enter into any form of settlement regarding an accident which my covered dependents or I are injured as a result of the acts of a third party. I will do whatever is reasonably needed to secure the Carrier's rights and shall do nothing to damage such rights. I will abide by this agreement only if my health insurance policy contains language that gives the health insurance carrier subrogation and rights of reimbursement.

### \_\_\_\_ **X-RAY CONFIRMATION FOR FEMALE PATIENTS**

This is to confirm that this office advises me that x-rays can be hazardous to an unborn child. If x-rays are required during the course of my care with Lavan Family Chiropractic, LLC, I will notify the x-ray technician if there is a chance I may be pregnant.

The undersigned agrees to execute any additional documents necessary to implement the foregoing provisions.

### \_\_\_\_ **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

This is to confirm that I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment, obtain payment from third party payors and conduct normal healthcare operations such as quality assessments and accreditation.

Patient's Name and Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Patient, Agent or Representative's Signature**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Date**