ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION

I, the undersigned, hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities (“payers”), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions accidents, injuries, or illness, past, present, or future (“condition”) to pay directly and exclusively in the name of Chiropractic Enterprises dba Pee Dee Chiropractic (“Office”) such sums as may be owing to Chiropractic Enterprises dba Pee Dee Chiropractic for charges incurred by me at the Office relating to my condition (“charges”), with such payments to be made exclusively in the name of Chiropractic Enterprises dba Pee Dee Chiropractic. I further grant a lien to Chiropractic Enterprises dba Pee Dee Chiropractic with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, “Assignment and Lien”), “benefits” shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments, benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverages, third-party liability distributions, disability benefits, worker’s compensation benefits, and any other benefits or proceeds payable to me for the purpose stated herein.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of Chiropractic Enterprises dba Pee Dee Chiropractic.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to Chiropractic Enterprises dba Pee Dee Chiropractic any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims, I hereby direct this Office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Chiropractic Enterprises dba Pee Dee Chiropractic to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Chiropractic Enterprises dba Pee Dee Chiropractic to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of weather or not these other charges are related to my condition.

This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Chiropractic Enterprises dba Pee Dee Chiropractic for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Chiropractic Enterprises dba Pee Dee Chiropractic and myself. I hereby revoke any previously signed authorizations, whether executed at this Office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

Patient Name (please print)____________________________________________________________

Patient Signature ______________________________________ Date ______/______/ ______

Name of Custodial Parent or Legal Guardian (please print) _____________________________________

Parent/Guardian Signature ______________________________________ Date ______/______/ ______

Witness _____________________________________________________ Date ______/______/ ______
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:______________________________________________________________

Address:_______________________________________________________________________

Telephone:_____________________________ Email:__________________________________

Social Security Number_____________________

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare policies.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we may obtain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Pee Dee Chiropractic
2234 W. Palmetto Street
Florence, SC 29501

Right to revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this consent before receiving your revocation, and that we may decline to treat you if you revoke this consent.

Signature:

I,______________________________________, have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare options.

Signature:_________________________________________________________ Date__________________________________

If consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative’s Name:______________________________________________________________

Relationship to Patient:______________________________________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT LETTER
Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time. However, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of ________________________. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

___________________________________________________________  __________________________
Patient name printed                               Date

___________________________________________________________  __________________________
Patient’s signature                               Authorized provider representative

___________________________________________________________  __________________________
Personal representative printed                   Personal representative signature