Financial & Insurance Authorization
HIPAA Consent

PATIENT NAME **DATE**

AUTHORIZATION

I hereby give my consent to the doctors, staff and associates of Metairie Chiropractic & Rehab to provide chiropractic services to myself and/or family. I understand and agree (regardless of my insurance status) that I am responsible for the balance of my account.

RESPONSIBLE PARTY SIGNATURE _____ **DATE** _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Metairie Chiropractic & Rehab all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE _____ **DATE** _____

INSURANCE POLICY

Changes made daily among insurance companies, make it impossible for us to accept the responsibility of knowing if your plan dictates benefits, payment, coverage and whom you can and cannot see. As a service to you, we will file your insurance claim. In order for us to file your insurance, please provide all insurance information o the day of your visit. **It remains the responsibility of the patient to know his or her own plan.** As a service to you, we will call your insurance company for an estimate of what they will pay. It is important to know that any information given over the phone cannot be guaranteed and is only an **estimate.** The day of your treatment, we require you pay your estimated difference between insurance payments and the provider charges.

RESPONSIBLE PARTY SIGNATURE _____ **DATE** _____

MEDICARE AUTHORIZATION (if patient has Medicare)

I request that payment of authorized Medicare benefits be made on my behalf to Metairie Chiropractic & Rehab for services rendered. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents an information needed to determine those benefits payable to related services. I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 on the HCFA-1500, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE _____ **DATE** _____

HIPAA CONSENT

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for chiropractic care by Dr. Tekippe and the staff at Metairie Chiropractic & Rehab.

PATIENT SIGNATURE _____ **DATE** _____
SIGNED BY _____ **RELATIONSHIP (if other than patient)**_____
WITNESS_____