MAINE CHIROPRACTIC HEALTH CLINIC, PA

Luc J. Dionne D.C.

INSURANCE ASSIGNMENT

Our patients should understand and agree to the following:

1. You will be considered a cash patient until we qualify and accept your coverage.

2. You will be ultimately responsible for full payment of any and all services rendered.

3. Co-insurance and co-payment must be paid at the time of service, or once a week.

4. You must pay all deductibles in full.

5. If your insurance carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim, and after 90 days you will be responsible for payment in full of any outstanding balance. 10% Interest will be added to your account after 90 days for delinquent payments.

6. If you are without any health insurance coverage you then qualify as a cash patient. Payment will be expected at time of service unless you have been approved for a payment plan by our billing department. Our office accepts check, cash, debit card, credit card and CareCredit as method of payment.

7. Our office reserves the right to use a collection agency for any unpaid balance, plus any fees incurred. **All fees** related to collection efforts will be added to the account. Collection fee of $25.00 will be added to account balance.

8. It is the patient's responsibility to make sure that we receive any required referrals from their Primary Care Physician for chiropractic services.

9. All durable orthopedic supplies are payable by the patient. Supplies such as Custom Fitted Orthotics, pillows, ice packs, gels or supplements are non-refundable. unless defective.

10. I hereby authorize payment of benefits directly to Luc J. Dionne, D.C. for services rendered. I further authorize Maine Chiropractic Health Clinic, PA/Luc J. Dionne to release any information required to process insurance claims.

I hereby acknowledge that I have read and understand this form.

Patient's Name : _____ Date: _____

Signature of Financially Responsible Party: _____

120 Russell Street • Lewiston ME 04240 • ☎ 207-786-0393 • Fax: 207-795-0661

MAINE CHIROPRACTIC HEALTH CLINIC, PA

Luc J. Dionne, D.C.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ D.O.B.: _____

Address: _____

I hereby authorize Maine Chiropractic Health Clinic, P.A./Luc J. Dionne, D.C. to release my medical records to:

_____

I understand that my medical record may contain sensitive information, including information regarding, AIDS, ARC, HIV, DRUG/SUBSTANCE ABUSE, SEXUALLY TRANSMITTED DISEASE, MENTAL ILLNESS, OR SEXUALLY ALLEGED SEXUAL ABUSE.

I have carefully read this form and I wish to have the designated medical information release. I understand that Maine Chiropractic Health Clinic, P.A. and those associated with his/her office have kept the information in my medical record in strict confidence, and expect that these records will be used only for the purpose for which they are requested and shall be held in a confidential manner to which I am entitled.

I will not hold Maine Chiropractic Health Clinic, P.A. responsible for any misuse of this information, which may occur. *A copy of this authorization shall be as valid as the original.*

_____ _____

Signature (patient or guardian) Date

_____

Witness

We respectfully request the following:

☐ Medical report(s) ☐ X-ray report(s) ☐ Blood test result(s)

☐ Hospital record(s) ☐ MRI report(s) ☐ Other: _____

☐ Office note(s) ☐ X-ray film(s)

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Luc J. Dionne, D.C.

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

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 and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient (print)

_____

Signature Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (Please Specify) _____
- ☐ _____

_____

Staff signature Date

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