OKC WELLNESS

AUTHORIZATION AND ASSIGNMENT

To: OKC WELLNESS OF MOORE/NORTH OKC/SOUTH OKC
DR. MATT DAVIS/ DR. VINCENT GONZALEZ/ DR. TERRY HILL/ DR. LANCE WILLIAMS/ DR. RYAN WILSON

In consideration of your undertaking to render care and treatment to me, I agree as follows:

1. I authorize you to release any information deemed appropriate concerning my condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred for services rendered.

2. I further authorize and direct any insurance company and/or my attorney, to pay directly to you such sums as may be due and owing for services rendered to me, and to withhold such sums from any disability benefits, including, but not limited to, governmental agency benefits, medical payments benefits, health and accident benefits, workers compensation benefits, or other insurance benefits or from any settlement, judgment or verdict on my behalf as may be necessary to adequately pay for any financial obligation owed to you by me.

3. I further agree that in the event an insurance company may be obligated to make payments to me for the charges made by you for services, and it refuses to make such payments, this agreement will serve as an assignment by me to you of all my rights and benefit to the extent of the charges of services provided. Further, I hereby assign and transfer to you any, and all causes of action that I might have or that might exist in my favor against such insurance company and authorize you to prosecute said cause of action either in my name or in your name and further I authorize you as my assignee to compromise, settle, or otherwise resolve said claim or cause of action as you see fit. I further agree to fully cooperate with you in all phases of such cause of action, and I further understand and agree that I shall remain obligated and bound to pay you for your services in the event that no sums are realized and received by you from my attorney or any insurance company.

4. Thereby further to you a lien against, and an assignment, of any, and all insurance benefits that I may have and any, and all proceeds of any settlement, judgment, or verdict which may be due to me as a result of the injuries or illness for which I may be treated by you.

5. As the responsible party, I have been advised that once payments on this account are past due for over thirty days, I may be responsible for a finance fee of 22% to be compounded annually. In addition, past-due accounts may be turned over to collections. The responsible party agrees to reimburse and pay OKC Wellness for any expenses, attorney fees, and/or any other costs related to the collection of past-due accounts.

I attest that I have come to this clinic for the purpose of acquiring medical/chiropractic care. I am here for help regarding my medical problems and have no intent to mislead or defraud my treating practitioners in any way that might result in inappropriate charges to third-party payers, federal, state, or local governments, or insurance carriers. Further, I attest that my injuries are real and that I am in pain and in need of medical treatment as a result of the medical condition for which I am consulting your clinic. I also attest that I understand the context of this statement with complete comprehension of this content.

Date:_____ **Patients Name:**_____

Patient Signature_____

Witness Signature_____

Date of Injury:_____ Name of Insurance Company:_____

Patients Insurance Co.:_____ Policy or Claim #:_____

Insurance Beneficiary Notice

The purpose of this form is to help you make an informed decision about your healthcare.

Our office and staff will do their best to verify your insurance benefits and explain them to you, but we do determine your benefits. The insurance carrier has the final determination when claims are submitted.

Any discussion of benefits by OKC Wellness staff is not a guarantee of payment or benefits.

I understand it is my responsibility to know and understand how my insurance works and how benefits are applied.
I have been advised to call my insurance carrier for a quote for chiropractic benefits.

I understand it is my responsibility to provide documentation and cooperate with my insurance carrier promptly regarding my claims. I have been advised that failure to provide the requested information will close my claim without payment, and I will be responsible for the total charges.

I understand I am responsible for notifying OKC Wellness Clinics of any changes to my insurance carrier, employer, or benefit status. I understand claims that are denied because I did not provide this information promptly will be my full responsibility.

I understand that OKC Wellness Clinics estimates deductible, copay, and coinsurance at the time of my visit, but the final determination of benefits is made by my insurance company after a claim is filed. I understand I may owe additional money after the insurance carrier has processed my claim.

I have read and understand this notice.

Patient Signature_____ Date:_____

Witness Signature_____