Atlas Specific Chiropractic
Health from the Top of Your Spine

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# Assignment of Benefits / Authorization for Treatment

I hereby authorize treatment and authorize the provider of chiropractic services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made directly to Atlas Specific Chiropractic on my behalf. I understand that I am ultimately responsible for any amount not covered by my insurance carrier, and that all co-payments and deductibles are due at the time of service. Should I present for an appointment without securing necessary authorizations/referrals, as required by my insurance carrier, I agree to accept responsibility for charges in full if I am unable to provide the information to the office on date of service. I understand that the patient is ultimately responsible for his/her won policy. Should I choose to be treated by a non-participating facility, I elect to be held responsible for all charges accrued. I also understand that a charge may be assessed for missed appointments if 24 hours notice is not provided and that my insurance carrier does not provide payment for any cancellation charges.

**Should my account become delinquent, I agree to assume responsibility for any and all collection expenses, court costs and attorney fees and these charges will be added to my account.**

I HAVE READ THIS ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY AND UNDERSTAND ITS CONTENTS AND AGREE TO THE TERMS STATED.

I PERSONALLY GUARANTEE PAYMENT OF THIS ACCOUNT:

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|---|---|
| Patient Name (printed) | Relationship to patient |
| Patient or legal Guardian Signature | Date |
| Witness Signature (office staff) | Date |