MALKMUS

Chiropractic Acupuncture

Assignment of Benefits

The following policies outline your financial responsibility to Malkmus Chiropractic & Acupuncture LLC should you choose to receive care. In addition, this document authorizes your insurer to provide payment on your behalf. Please read the following policies carefully and ensure that you fully understand their meaning. Marking your initials following each policy indicates that you have read and fully understand the policy.

Financial Responsibility

All professional services rendered are charged to the patient by a CASH-BASED PRACTICE model. Currently, this is the practice model adopted by Malkmus Chiropractic & Acupuncture LLC. I agree to pay in full and at the time of service, unless other arrangements have been made in advance with our business office. I additionally acknowledge that I am personally responsible for all charges, regardless of any insurance coverage. Though I may choose to submit claims to my insurance carrier for possible reimbursement but understand that any such reimbursement is between myself and my insurance provider. If applicable in the future, Malkmus Chiropractic & Acupuncture LLC takes on an insurance model practice, then I acknowledge necessary forms will be completed to file for insurance carrier payments. ***By initialing below, I verify that I have read and understand the financial responsibility policies set forth.***

_____ (Initial)

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Malkmus Chiropractic & Acupuncture LLC for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. ***By initialing below, I verify that I have read and understand the assignment of benefits policies set forth.***

_____ (Initial)

Phone: (417) • 614 • 5222 | Email: info@malkmuschiropractic.com | Fax: (417) • 614 • 2288

2053 S. Waverly Ave, STE B, Springfield, Missouri, 65804

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Authorization to Release Information

1. I hereby authorize Malkmus Chiropractic & Acupuncture LLC to: (I.) release any information necessary to insurance carriers regarding my illness and treatments; (II.) process insurance claims generated during examination or treatment; and (III.) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

2. I have requested medical services from Malkmus Chiropractic & Acupuncture LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for all charges incurred during authorized treatment.

3. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

PLEASE DO NOT SIGN UNTIL YOU HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT IN ITS ENTIRETY

(Print): _____ (Signed): _____ (Date): ____/____/_____

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