QC Core Chiropractic Wellness Center

ASSIGNMENT AND RELEASE: I, the undersigned certify that I have insurance coverage with the company and assign directly to Picchiotti Wellness Center 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 the payment of benefits. I authorize the use of this signature on all insurance submissions.

CONSENT FOR TREATMENT: I hereby authorize Picchiotti Wellness Center and the staff to perform diagnostic tests and render care considered therapeutically necessary on the basis of findings during the course of my treatment. As of the date stated below, I have the legal right to select and authorize health care services for the patient named above. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify Picchiotti Wellness Center I hereby certify that I have read and fully understand the above Authorization for Chiropractic Treatment. I also certify that no guarantee or assurance has been made as to the results that may be attained.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company. It is Picchiotti Wellness Center's policy that all payments are due at the time of service, including copays and deductibles. It is our policy not to send statements.

All past due accounts are subject to a finance charge of 1.5% per month or maximum rate allowed by law. The undersigned responsible party promises to pay for services in accordance with the above terms. If, at any time, for any reason, the undersigned is unable to pay for services when due, the undersigned agrees to pay and authorizes Picchiotti Wellness Center to bill their account finance charges as described above. In the event it becomes necessary for Picchiotti Wellness Center to incur collection costs or institute suit to collect any amount due under this agreement, the undersigned promises to be responsible for charges incurred, to pay all additional costs, charges, collection fees and expenses, including reasonable attorneys' fees and costs, if incurred for the collection or otherwise and submits to jurisdiction and venue in Scott County, Iowa.

PRIVACY STATEMENT: In general, the HIPPA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the patient's office instead of their home. Occasionally our office will send out postcards, call you regarding an appointment, etc. Please let us know which form(s) of communication you would prefer to be contacted by. By signing this form, I am acknowledging that I have been notified of the Privacy Practices utilized in this office and have received a copy. I may be contacted in the following manner (check all that applies):

Home Telephone_____

___O.K. to leave message with detailed information

___Leave message with call-back number only

Work Phone_____

___O.K. to leave message with detailed information
___Leave message with call-back number only

Cell Phone_____

___O.K. to leave message with detailed information

___Leave message with call-back number only

Written Communication

___O.K. to mail to my home address

___O.K. to mail to my work/office address

___O.K. to fax to this number_____

___O.K. to e-mail to_____

Other_____

_____

_____

SIGNATURE_____ **DATE** _____

Patient (over 18 years) or responsible party