

Couture Chiropractic Center
Denise T Couture
401 Lafayette Center, Kennebunk, ME 04043

Patients Name _____ Age _____ DOB ____/____/____ Gender M F

AUTHORIZATION AND ASSIGNMENT TO PAY CLAIMS DIRECTLY TO DOCTOR

To (Attorney, Insurer, Employer, Other) _____

In consideration of the undertaking, by Couture Chiropractic Center:
Denise T. Couture D.C.

I, Do or Do Not (circle one)

understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to that point, will be immediately due and payable.

- A. In consideration of the chiropractic services rendered and to be rendered by Denise Couture D.C. I authorize the Payments of benefits to Denise Couture D.C. in the amount of any sum I now or hereafter owe by my attorney or out of the proceeds from any settlement of any liability case or by any insurance company obligated to make payment to me or Denise Couture D.C. based in whole or in part, on the charges accrued for said services.
- B. If a liability claim exists and my attorney or insurance carrier refuses assignment, I acknowledge my personal financial responsibility for the payment in full of my outstanding balance.
- C. I further agree that this Authorization and Assignment is irrevocable until all monies owed to Denise Couture D.C. has been paid in full.

PATIENT ACKNOWLEDGEMENT OF HIPPA NOTICE OF PRIVACY ACT

I, Do or Do Not (circle one)

Hereby acknowledge the receipt (at my request) or opportunity to review the Notice of Privacy Practices Act (HIPPA) for Couture Chiropractic Center regarding my personal health care information. I am or have been informed and clearly understand the manner in which my health information shall be maintained, utilized and disclosed by the center and the respective rights contained within.

I also understand that the Notice of Privacy Act that is available upon my request is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting or making a written request to:

Denise T. Couture D.C.
401 Lafayette Center
Kennebunk ME 04043

Phone # (207)985-7133 Fax # (207)985-7134

My signature herein below constitutes full acknowledgement that I have been furnished the opportunity to review or obtain a copy of the Notice of Privacy Practices for:

I have reviewed the medical information provided and I believe it to be true and accurate to the best of my knowledge.

Patient Signature

Date

Patient's Legal Representative (If required)

Date

If signed by a legal representative. indicate relationship: