Advanced Chiropractic Relief

Dr. Gregory E. Johnson, D.C.

INSURANCE ACKNOWLEDGEMENTS & ENDORSEMENTS

PATIENT LEGAL NAME: __________________________________ DOB______/_____/_______

RECORDS RELEASE

I, hereby Authorize Dr. Gregory E. Johnson, D.C., DBA, ADVANCED CHIROPRACTIC RELIEF to furnish any medial records and/or any other necessary information needed to process an insurance claim.

_____________________________________ _______________________ ______/______/___________

Signature of Responsible Party **Printed Name** **Date**

ASSIGNMENT OF BENEFITS

I, the undersigned, am the financially responsible party for the patient named above and agree to pay, in full, Dr. Gregory E. Johnson, D.C., DBA, Advanced Chiropractic Relief, et al for all services rendered. I accept Dr. Johnson's fees as reasonable and customary.

In order to process an insurance claim, there must be complete patient insurance information on file with this office.

I irrevocably assign to Dr. Gregory E. Johnson,D.C., DBA, Advanced Chiropractic Relief and/or it's assignees all payment from my insurance company(ies) for Chiropractic services rendered and accept responsibility for paying any balance owed after the insurance has paid.

All patients whose insurance providers pay the patient directly, rather than, Dr. Gregory E. Johnson, D.C., DBA, Advanced Chiropractic Relief, hereby agree to assign all benefit proceeds the patient receives from the insurance company to the office of Dr. Gregory E. Johnson, D.C., DBA, Advanced Chiropractic Relief. I agree to immediately endorse all checks received from any insurance company and to mail and/or bring in person, any such checks, to this office.

_____________________________________ ____________________________ _____/________/_____________

Signature of Responsible Party **Printed Name** **Date**

NON-WORKERMANS COMP DECLARATION

PLEASE READ- **DR.GREGORY E. JOHNSON, D.C., IS UNABLE TO DETERMINE WHETHER OR NOT THE SYMPTOMS YOU ARE SUFFERRING FROM ARE WORK RELATED.**

By signing below you declare that you do not have a compensable work injury covered under a workman's comp claim at this time.
It is your responsibility as the patient to notify this office if you have a workman's comp claim.

You also understand that should your workman's comp claim be denied, you will be responsible for all balances due in full. If group health insurance is available, we must receive a copy for processing as soon as you are aware the claim has been denied. This is not a guarantee that I accept your group insurance.

______________________________________ ______________________________ _____/_____/__________

Signature of Responsible Party **Printed Name** **Date**