Kearney Family Chiropractic Center, LLC

301 S. Platte Clay Way, St. B, Kearney, MO 64060 Phone: 816 / 628-6738 Fax: 816 / 628-6739

Dr. Mark Strathman, DC

COMMERCIAL ASSIGNMENT OF BENEFITS & RELEASE:

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE AND, IN CONSIDERATION OF SERVICES RENDERED, ASSIGN DIRECTLY TO KEARNEY FAMILY CHIROPRACTIC CENTER, LCC ALL PAYMENTS FROM MEDICAL HEALTH BENEFITS, AND / OR ANY PAYMENTS FROM MY ATTORNEY, THIRD PARTY PAYOR, MEDICAL / PIP COVERAGE, IF ANY, OTHERWISE PAYABLE TO ME. I AUTHORIZE THE RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

PATIENTINITIALS_____

MEDICARE AUTHORIZATION:

I REQUEST PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO KEARNEY FAMILY CHIROPRACTIC CENTER, LLC, FOR ANY SERVICES FURNISHED TO ME BY SAID PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO KEARNEY FAMILY CHIROPRACTIC CENTER, LLC AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT MEDICARE & MEDICARE ADVANTAGE INSURERS REQUIRE AN EXAM AND NECESSARY X-RAYS; HOWEVER, MEDICARE AND MEDICARE ADVANTAGE INSURERS **DO NOT COVER** ANY CHARGES FOR **EXAM, X-RAY, OR THERAPY**.
MEDICARE & MEDICARE ADVANTAGE INSURERS COVER **SPINAL ADJUSTMENTS ONLY.**

PATIENTINITIALS_____

AUTHORIZATION TO DISCLOSE INFORMATION:

I, THE UNDERSIGNED, HERE BY AUTHORIZE KEARNEY FAMILY CHIROPRACTIC CENTER TO RELEASE ANY AND ALL INFORMATION REGARDING MY CONDITION, TREATMENT, AND FINANCIAL STATUS AS IT RELATES TO MY CASE TO THE FOLLOWING:

1.) _____ PHONE #: _____
2.) _____ PHONE #: _____

Notice of Privacy Practices

I acknowledge that I have **received and had the opportunity to review** the **Notice of Privacy Practices** on the date below on behalf of Kearney Family Chiropractic Center.
I understand that the Notice describes the uses and disclosure of my protected health information by Kearney Family Chiropractic Center and informs me of my rights with respect to my protected health information.

_____ _____
Patient's Signature or that of Legal Representative Printed Name of Patient or that of Legal Representative

_____ _____
Today's Date If Legal Representative, Indicate Relationship

FOR OFFICE US ONLY:

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- Communication barriers prohibited obtaining the acknowledgement

Other (please specify):