INSURANCE INFORMATION

Primary Insurance: ______________________________ Telephone # ______________

Address ______________________ City ______________ State ________ Zip__________

Name of Policy Holder______________________________ Date of Birth _____/_____/_____

Relationship to Patient________________ Employer______________________________

Member Id #______________________ Group Id #____________ Social Security # ____________

Secondary Insurance: ______________________________ Telephone # ______________

Address ______________________ City ______________ State________ Zip__________

Name of Policy Holder ______________________________ Date of Birth _____/_____/_____

Relationship to Patient ________________ Employer______________________________

Member Id #______________________ Group Id #____________ Social Security # ____________

HIPPA/ INSURANCE AUTHORIZATION & RELEASE

HIPAA COMPLIANCE

- Your personal health information cannot be shared unless to prevent serious threat to your health or others.
- Your personal health information may be disclosed, if required to do so by law.
- You have the right to access your medical file and billing records.
- You have the right to request that we amend your information.
- You may revoke any written authorization given to us.
- All requests must be presented to this office in writing.

I allow my treatment to be discussed with ______________________ Relationship______________

INSURANCE ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **Kim Borselli, D.C.** I authorize **Kim Borselli, D.C.** to release any information required to process my claims. I understand it is my responsibility to make sure my account is paid by my insurance company. I have verified with my insurance company that **Kim Borselli, D.C.** is a participating provider. I understand that I am fully financially responsible if there are any unpaid claims by my insurance company for any reason.

LIMITED POWER OF ATTORNEY

I hereby authorize, make and appoint **Kim Borselli D.C.** as my Power of Attorney to endorse checks and negotiate any and all insurance drafts or checks pertaining to medical benefits and to file such claims or complaints as necessary to effect insurance payment. Giving and granting unto **Kim Borselli, D.C.** full power and authority to do and perform acts as necessary in my name in order to effect the purpose of this limited power.

DIAGNOSTIC FILMS ARE PROPERTY OF THIS OFFICE

The fee paid for X-rays and radiographs is for analysis only. The original film itself is property of this office. Once films are used for treatment purposes they can be released to another provider for review with your consent. Copies of films or radiographic reports are available at normal office fees.

COPY AS AFFECTIVE AND IRREVOCABLE AS ORIGINAL

A photo copy or NCR form of this assignment, agreement, release, limited power and property or other office forms shall be considered as effective and valid as the original. The authority granted shall become effective upon signing and be irrevocable for the full extent of my treatment by the doctor and until the time that all medical expenses incurred have been paid in full.

Patient accepts responsibility to report change in health status

Patient Signature: ______________________________ Date: ______________