ACTIVE HEALTH CENTER
1713 A. SOUTH MAYS STREET, ROUND ROCK, TEXAS 78664
(512) 310-2747
FAX: (512) 310-2759

Please Print all Answers

NEW PATIENT INFORMATION

Name _____ Age _____ Sex _____ Date _____

Address _____ City _____ Zip _____

Phone _____ Work _____ Cell _____

Best time to Call _____ Which # _____ E-mail _____

Social Security # _____ Birthdate _____ Family Doctor _____

☐ Married ☐ Single ☐ Sep ☐ Divorced ☐ Widowed Spouse's Name _____

Employer _____ Spouse's Employer _____

Employer Address _____ Spouse's Birthdate _____

Employer Phone _____ Spouse's Social Security _____

Parent's Employer If Patient Is Minor / Child _____

Parents Social Security # If Patient Is Child _____

Emergency: Who Do We Call? _____ Relationship _____

Name of Relative or Friend Not Living with You Phone

REFERRAL INFORMATION

WHO recommended you to our office? ☐ My Doctor ☐ Family / Friend ☐ _____

Name _____ Address or Phone _____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

Name of Insured (Policy Holder) _____ Policy Number _____

Insured Birthdate _____

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company _____

Agent Name _____ Adjuster's Name _____

Accident Claim Number _____ Phone Number _____

Name of LIABLE Insurance Company _____ Adjuster's Name _____

Claim Number _____ Phone Number _____

Attorney Name _____ Phone Number _____

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party _____

Contact Person _____ Phone Number _____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

Welcome to our multi-specialty group practice, offering family practice & pain management medical care, chiropractic, physical therapy, rehabilitation, acupuncture, massage therapy, nutritional & psychological counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. If you do not show up for your scheduled appointment you will be charged $15.00 as a missed appointment fee that you must pay before you are seen or treated again. We are available to immediately see new patients the same day or through our 24 hour - 7-day emergency service. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

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SYMPTOM SURVEY

What is your chief problem or symptoms? _____

What caused the problem or symptoms to occur? _____

When did the problem or symptoms begin? _____

Have you seen another doctor for this problem? □ No, If yes, who _____

What tests/procedures have been performed? □ X-Ray □ MRI □ Surgery □ Hospitalization □ _____

Have you had this problem or symptoms in the past? □ No, If yes, explain _____

Have you tried any other treatments for this? □ No, If yes, explain _____

Is the problem or symptoms getting worse? □ No, If yes, explain _____

√ ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

□ Arthritis / Gout	□ Depression/Anxiety	□ Pregnancy	□ Seasonal Allergies	□ Headaches
□ Eye Pain–Strain	□ Dizziness	□ Seizures	□ Ringing in Ears	□ Blurred Vision
□ Jaw Pain	□ Bleeding Gums	□ Neck Pain / Spasms	□ Chronic Fatigue	□ Heart Disease
□ Gall Stones	□ Swallowing Difficulty	□ Thyroid Problems	□ Chest Pain	□ Chest Congestion
□ Anemia	□ Hypertension	□ Stroke	□ Kidney Stones	□ Pancreatitis
□ Shortness of Breath	□ Irregular Heart Beat	□ HIV / AIDS	□ Asthma/Bronchitis	□ Mid-Back Pain
□ Shoulder/Elbow Pain	□ Wrist or Hand Pain	□ Low Back Pain	□ Hip/Knee/Leg Pain	□ Foot or Ankle Pain
□ Abdominal Pain	□ Diabetes	□ Groin or Rectal Pain	□ Female Disorders	□ Urinary Problems
□ Skin Problems	□ Broken Bones	□ Digestive Problems	□ Nausea – Vomiting	□ Irregular Bowels

PATIENT & FAMILY HISTORY

What is your occupation? _____ ☐ Full Time ☐ Part Time

What is your employment status? ☐ Working ☐ Sick Leave ☐ Unemployed ☐Retired
☐ Temp Disability ☐ Perm Disability Last Day of Work _____

Do you use tobacco? ☐ No ☐Yes Explain: _____

Do you consume alcohol? ☐ No ☐Yes Explain: _____

Do you have a history of substance abuse? ☐ No ☐Yes Explain: _____

List all past surgeries _____

List all drug allergies _____

List all current and past medications / drugs

Drug Name: _____ _____

_____ _____

_____ _____

List all physicians you have seen in the past 5 years?

Name _____ For What? _____

_____ _____

_____ _____

_____ _____

Family History

Father	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Mother	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Brother	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Brother	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Sister	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Sister	□ Living	Age: _____	□ Deceased – Cause of Death	_____

□ Other problem(s) not listed _____

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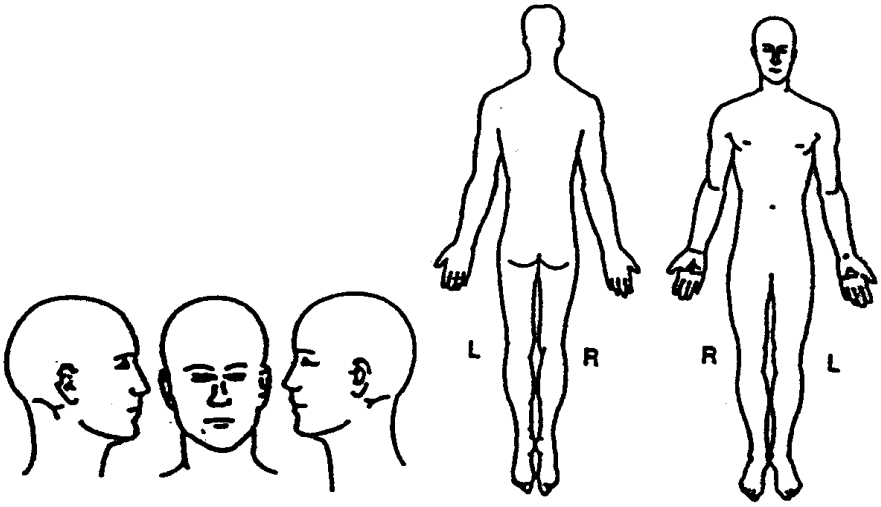
PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

PAIN	: : : : : : : : :
NUMBNESS	+ + + + + +
BURNING	/ / / / / / / / / /
ACHE	X X X X X X

Describe your pain (check all that apply):

- □ Constant
- □ Intermittent
- □ Recurring
- □ Stabbing
- □ Dull Ache
- □ Sharp
- □ Deep Ache
- □ Throbbing
- □ Tingling
- □ While Resting
- □ Daily
- □ During Exercise
- □ Nightly
- □ _____



Onset of Pain:

- □ Sudden
- □ Gradual

On a scale of 1 to 10 how would you rate your pain level? _____ (1 = Mild, 10 = Intense)

What if anything gives you relief? _____

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

□ **AUTO ACCIDENT** Date _____ Time ____ [am] [pm] Location_____

Were You	□ Driver	□ Passenger
	□ Unconscious	□ Treated in E.R.
	□ Wearing a Seat Belt	□ YES □ NO
	□ Transported by Ambulance	□ YES □ NO
Vehicle Damage	□ Minimal – Moderate	□ Severe - Totaled
	Was the vehicle towed away?	□ YES □ NO
Police Report	□ None	□ Yes with Police Dept_____
Activities	□ No restrictions	□ Missed ____ days of work or school
	□ I felt fine before the accident	

□ **WORK RELATED** or Other Injury Date _____ Time ____ [am] [pm] Location _____

Describe injury and how it happened:

_____

_____

_____

Accident Reported to _____ on _____(date)

- □ No restrictions
- □ Missed ____ days of work or school
- □ I felt fine before the injury

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HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
6. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
8. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient

X

Signature (if minor, parent must sign)

Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name_____ Date_____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache	Neck	Low Back	
No pain				worst possible pain
0 1	(2) 3 4	(5) 6 7	(8) 9 10	

---

1 – What is your pain RIGHT NOW?

No pain_____worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain_____worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain_____worst possible pain
0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain_____worst possible pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

HEALTH CARE PRIVACY NOTICE

Active Health Center _____, Compliance Officer

Our staff is committed to maintaining the privacy of your protected health information known as (PHI). PHI is information about you, including demographic information, that may identify you and that may relate to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and ask any questions, misunderstanding or concern to the Compliance Officer of this office.

This office is required by law to abide by the terms of this Health Care Privacy Notice as well as all other applicable federal and state laws governing privacy practices in health care. Our office may change and/or modify the terms of this Notice at anytime without additional notice to you except to publically post in our office and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request.

USE & DISCLOSURE OF PHI

Our office may use & disclose your PHI for health care delivery purposes. Your PHI may be used by doctors and staff of this office for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. Following is a list situations in which your PHI can be disclosed without your written authorization.

Business Associate: Your PHI may be used or disclosed to a business associate, from whom we have obtained assurances that they will safeguard your PHI and use it only for the purposes for which it was intended.

Emergency Situations: In an emergency situation, where written acknowledgment from you is not practical until after the emergency situation has ended.

Employee Limitations: Your PHI will be limited to the members of the clinic and its workforce who may need access for treatment, payment or health care operations

Health Care Operations: For certain administrative, financial, legal, and quality control activities that are necessary to run its business and support the core functions of treatment and payment.

Legal Proceeding: If requested by judicial or administrative proceedings, court order, subpoena or law enforcement purposes.

Minimum Necessary Standard: The disclosure of and requests for your PHI will be the minimum required to accomplish the intended purpose.

Payment: The provider may disclose your PHI to third party and/or other party(ies) to obtain reimbursements and/or payments for your health care services.

Personal Representative: Your PHI may be disclosed to a person who is authorized by state law to act on your behalf in making your health care decisions

Public Health Purposes: Your PHI may be disclosed to legally authorized public health authorities for the purpose of the prevention, control, investigations, intervention, and reporting of disease, injury, disability and vital events such as births or deaths. Your PHI may be disclosed for public health activities such as child abuse, neglect, safety and effectiveness of a product regulated by the FDA, and persons at risk of contracting and spreading disease.

Research Purposes: Your PHI may be disclosed for research purposes either with your written permission or without any identifying characteristics.

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Treatment: For the coordination or management of your health care services, your health care provider may consult with another health care provider, a third party, or for the referral to another health care provider.

Worker's Compensation: State laws may permit disclosure of your PHI to comply with worker's compensation laws without your authorization and no minimum necessary standard is required.

Miscellaneous: We may use or disclose your PHI in the normal course of operations, notifying you of appointments, services, and clinic news.

The Privacy Rule allows you the right to review and receive copies of your records as it relates to your health care. The request must be in writing, allowing your doctor 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your doctor may charge a copy fee, which will not exceed the amount permitted by State Law

The Privacy Rule allows you the right to request that the disclosure of your PHI have restrictions on how your doctor will use your PHI regarding treatment, payment and health care operations. Your doctor may not agree to your restrictions, but would be bound by any restrictions you agree upon.

Your doctor must comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the doctor has the right to respond with a rebuttal statement if he/she feels it is necessary.

You have a right to receive your doctor's Notice of Privacy Practices.

You may revoke authorization, in writing, at any time, except in the event that the doctor has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer, and it must be filed within 180 days of when you knew or should have known that the violation occurred. You may also contact a written complaint, either on paper or electronically with the Office of Civil Rights (OCR). The Privacy law prohibits our office from taking any retaliatory actions against anyone who files a complaint.

I, _____,(patient's name) acknowledge that I have read and was given a copy of the Notice of Privacy Practices for the Active Health Center and fully understand the same and have all my questions answered to my satisfaction.

Patient's Signature	Date
Signature of Compliance Officer	Date

ASSIGNMENT, LIEN, AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to Dr. Kevin Handcock, 1713 A South Mays Street, Round Rock, Texas 78664, such sums as may be due and owing this Office for services rendered me by reason of accident or illness that are due this Office and to withhold such sums from any disability benefits, medical payments benefits, No-fault benefits, health and accident benefits, workers' compensation benefits or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect this Office. I hereby further give a lien to this Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by this Office. I hereby assign all my rights, title and interest to the extent of services provided by this Office.

In the event my insurance company, obligated to make payments to me for charges made by this Office for their services, refuses to make such payments to me or to this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due this Office for their services. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for this Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize this Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien, and Authorization. I agree that the above mentioned Office be given power of attorney to endorse or sign my name on any and all checks for payment of my doctor bill.

I UNDERSTAND THAT, IN THE EVENT I RECEIVE ANY BENEFITS FROM ANY SOURCE FOR THE SERVICES RENDERED TO ME BY DR. KEVIN HANDCOCK, THAT I AGREE TO BRING THE CHECK(S) DIRECTLY TO DR. KEVIN HANDCOCK OR I AM PERSONALLY RESPONSIBLE FOR THESE AMOUNTS.

Patient's Signature: _____

Patient's Printed Name: _____

Witness: _____

Date: _____

(A COPY OF THIS SHALL BE AS VALID AS THE ORIGINAL)

ACTIVE HEALTH CENTER

DR. KEVIN HANDCOCK

1713A South Mays Street
Round Rock, TX 78664
(512) 310-2747

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Our Office will accept your insurance on assignment. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility.

Our office will file your claims for you and assist you in every way possible to ensure benefit recovery.

Please read the following office policy regarding assignments.

1. At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office **DOES NOT** guarantee your insurance policy or payments.

2. Your insurance will be filed as a courtesy to you. We file insurance claims on a daily basis.

3. You are required to sign an "Assignment of Benefits" form and any other forms required by your insurance company on your second visit.

4. You will be responsible for your deductible and co-payment. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial.

5. Your insurance should pay within 60 days from the date on which it was filed.

6. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to pay.

7. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office *within 48 hours.*

8. Any overpayments made by your insurance company that credits your account will be refunded to them. However, any overpayments or errors in amounts paid which does not credit your account will be your responsibility.

I have read and understand the policy regarding insurance assignments.

I realize that I am responsible for all charges incurred by me at this office.

_____ _____

Patient Signature Date

_____ _____

Witness Date