HIPAA NOTICE OF PRIVACY PRACTICES

I have received and/or read the HIPAA Notice of Privacy Practices.

Print Name:_____ Signature:_____ Date:_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct _____ insurance company to pay by check made out and mailed directly to:

Porter Chiropractic PLLC 717 Wheatley Rd. Ashland, KY 41101

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. If I do or do not have insurance coverage I agree to pay in a current manner for professional services provided to me. I also agree that if I do not pay in a current manner Porter Chiropractic PLLC has the right to charge my account interest on any unpaid balance. A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_____ _____
Signature of Policyholder Date

_____ _____
Signature of Claimant, if other than policyholder Date

ATTENTION ALL PATIENTS

If your Insurance company requires Pre-Certification for our Patient procedures (i.e. MRIs, CT scans, lab work etc.) it is your responsibility to know this and alert us that this needs to be done prior to an testing the Doctor may order for you outside our office. If you fail to do this, we will not be responsible for any reimbursement penalties for uncertified procedures. We will be happy to assist you in this process.

If your Insurance requires that you get a referral from your Primary Care Physician . . . it is your responsibility to know this and to see this is taken care of on/before the day of your exam. If you fail to do so, you will be responsible for payment of the balance due.

I acknowledge that I am responsible for notifying Dr. Porter's office staff of any Pre-Certification my Insurance Company requires for testing that is performed outside the office. I also acknowledge that I am responsible for obtaining any necessary referrals from my Primary Care Physician. Again, our office will be more than happy to assist you or answer any questions.

Signed_____Date_____