

Good Health Chiropractic

Eligibility Guarantee and Assignment of Benefits

I, _____ hereby certify that I am eligible for Chiropractic benefits. I understand that if I am not eligible for any reason or have a deductible that is not satisfied I agree to pay in full for all services received. I understand I may be responsible for a co pay today.

I, _____ authorize the release of any health information necessary to process this claim.

I authorize my Medical Insurance to pay benefits directly to Dr Jamie Gutheil.

In case of emergency, please give our office the name and phone number of the person you would like us to notify. Name: _____

Phone Number: _____

Aside from your insurance company your health and billing records are kept private at Good health Chiropractic. Any use or disclosure of your protected health information other than as described in the examples outlined above, will only be made with your written authorization. Copies of your records will be made available to you within 48 hours upon a written request so long as those records are not over seven years old.

Your signature here indicates you have read this form in its entirety, understand and agree to its contents.

Signature of Patient, Parent or Guardian: _____

Date of Signature: _____