Michael C.Kennedy,D.C.

Patient Information

Full Name

Street Address *City, State, Zip*

Home Phone *Cell Phone*

Permanent Street Address *City, State, Zip*

Social Security Number *Date of Birth*

Authorization and Assignment Policy

It is my understanding that if I become a patient in this office, I agree to the following:

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I also understand that there is a possibility of denial of coverage by my insurance carrier, including Medicare, for services rendered in this office. Furthermore, I understand that Kennedy Chiropractic will prepare the necessary reports and forms to assist me in making a collection from the insurance company, and any amount authorized to be paid directly to Kennedy Chiropractic will be credited to my account upon being received.

Authorization to release information:
I am authorizing you to release any information you feel appropriate concerning my condition to any insurance company, attorney or adjuster in order to receive reimbursement on any charges incurred.

Authorization to Pay directly to Doctor:
I authorize the direct payment to you on any sum I now or hereafter owe you from any insurance company that is obligated to reimburse me for charges incurred in your office in part or in full or my attorney out of the proceeds of my settlement. I give limited power of attorney to you for endorsement of any check issued in my name (the patient) and/or jointly to the patient and provider by any party billed for services rendered. A photocopy of this form is acceptable for payment.

Assignment of Cause of Action:
I hereby assign and give to you the right to take action against any insurance company that is obligated by contract to make payment to me, including filing complaints with the insurance Commissioner. It is understood that all reasonable efforts will be made to collect from the insurance company before you will pay that amount to collect amounts owed directly from me. I also understand that should I receive the insurance check, I will pay that amount to your office within 6 days of receiving or be responsible for the entire amount billed.

For Personal Injury Cases:
I understand that in the event that there is no valid coverage, I will be responsible for all the charges incurred. Overdue accounts are subject to 1.8% interest per month.

This Authorization and Assignment shall be valid and effective for all charges and fees hereafter incurred unless retracted and revoked by me in handwriting.

Patients Signature

Date

Scottsdale Office
7901 East Thomas Road Ste 109
Scottsdale, AZ 85251

Michael C. Kennedy D. C.
3002 North 7th Ave.
Phoenix, Az. 85013