SCOMA CHIROPRACTIC, P.A.

DR. LOUIS SCOMA

1113 SE 47th Terr. #1
Cape Coral, FL 33904

(239) 945-1717
FAX (239) 945-1963
HOURS BY APPOINTMENT

HEALTH AND WELLNESS CENTER

Date: _____

Re: Receipt for Services/Medical Information Release

I agree to waive my right to a receipt for services at every visit, however at any point I may request a receipt for any or all services rendered. Also,

I hereby give SCOMA CHIROPRACTIC, P.A. full authority to discuss or release any information, which is related to my condition.

I hereby authorize any medical entity to release the following information to Scoma Chiropractic, P.A.

a. ANY AND ALL b. Reports/Office Notes c. Other_____

All medical records are secured against loss, destruction, unauthorized access, unauthorized reproduction, corruption, or damage. No medical records are released without a proper records release from you.

_____ _____

Patient's Signature Patient's Name (Please Print)

PLEASE TURN OVER

Scoma Chiropractic, PA

Dr. Louis Scoma

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Cape Coral, FL 33904

PH: 239-945-1717
FAX: 239-945-1963

Health and Wellness Center

RELEASE OF MEDICAL INFORMATION

DATE:_____

I, _____ give permission to SCOMA CHIROPRACTIC, P.A., to release medical information to the following family members:

NAME:_____ RELATION_____

NAME : _____ RELATION _____

A. I UNDERSTAND THAT I MAY REVOKE THE ABOVE AT ANYTIME in writing.

_____ DATE_____
PATIENT OR AUTHORIZED REPRESENTITIVE SIGNATURE

OR

B. I REQUEST THAT ALL MEDICAL INFORMATION BE DISCUSSED WITH ONLY ME AND NO OTHER FAMILY MEMBER.

_____ DATE_____
PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

PLEASE CHOOSE A OR B AND SIGN

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HEALTH AND WELLNESS CENTER

You will be explained your insurance benefits, unfortunately they not a guarantee of payment. The benefits explained to you, are based solely upon information which SCOMA CHIROPRACTIC, P.A. received from your insurance company. The actual payment will be based upon your plan's provisions.

I also understand that I am responsible for any services that my insurance company may deem NOT MEDICALLY NECESSARY or REIMBURSABLE.

By Florida Law insurance companies must pay claims within 45 days however due to Insurance companies failure to comply resulting from their use of stall tactics we will only bill your insurance once. We will bill your insurance company with a complete and correct claim form.

Beyond 45 days the full balance is your responsibility. Your payment is expected within 10 days of notification from this office.

If, we do receive additional payment from your insurance company we will issue you a check or credit your account.
A $25.00 re-billing fee will be added to your account for each month that your account is unpaid. For accounts over 10 days from notification and interest charge will be applied at a rate of 18% per year or 1.5% per month and the account will be sent to small claims court. You will be responsible for all attorney costs should they arise.

Patient's Signature _____ Date _____

PLEASE TURN OVER

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ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from Scoma Chiropractic, P.A. ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient _____ Date _____

Policyholder/Insured _____ Date _____