Cocoa Chiropractic Center

111 North Fiske Blvd. Cocoa, Florida 32922 (321) 636-6090

DR. PAUL M. LOMBARDI
CHIROPRACTIC ORTHOPEDIST

ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, and/or attorney, to pay directly to

Cocoa Chiropractic Center

such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payments, upon demand by me or 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 the Office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the 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/sign my name on any and all checks for payment of my doctor bill.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

Date _____ Signed:_____

Paul M. Lombardi, D.C., F.A.C.O.

Cocoa Chiropractic Center
111 N. Fiske Blvd- Cocoa, Fl 32922
Phone: (321) 636-6090

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read below and if you have any questions please feel free to ask on of our staff members.

Women Only:

To the best of my knowledge (I am / am NOT pregnant) and (I give my permission / don't give my permission) to X-ray me for diagnostic interpretation.
(Please circle one) (Please circle one)

Missed Appointments:

*There is a possible $20 fee charged for all appointments that are not cancelled prior to your scheduled visit.

Communication:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse:_____
Children:_____
Others:_____
_____**None**

May we leave messages on any answering device, i.e., home answering machines or voicemails? Yes [ ] No [ ]

I,_____, have read and fully understand the above statements.
(Signature)

Acknowledgement

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name_____ Signature_____ Date_____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY DR. PAUL LOMBARDI
ADDRESS	ADDRESS *Chiropractor* 111 N. Fiske Blvd. Cocoa, Fla. 32922
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other *(Specify)* _____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Entire Record
☐ Only information related to *(specify)* _____
_____
☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management (Health Records) Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Enter if different from one year after date below)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	DATE
SIGNATURE OF PERSONAL REPRESENTATIVE *(State relationship to patient) or Witness (if signature is thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION	NAME *(Last, First, MI)*	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH