

Tim Melton, DC
4545 Hartford St.
Abilene, TX 79605

AUTHORIZATION FOR CHIROPRACTIC CARE

I, the undersigned, a patient in this office, hereby authorize Dr. Tim Melton to administer such treatment as is necessary, and to perform therapy and adjustment and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand that AUTHORIZATION FOR CHIROPRACTIC CARE, the reason why the above treatment is considered necessary, its advantages and possible complication, if any, as well as possible alternative modes of treatment, which was explained to me by Dr. Melton.

I certify that no guarantee or assurances have been made as the results that may be obtained.

Patient Signature _____ Date _____

**** I ALSO UNDERSTAND THAT ANY CARE RENDERED AFTER NORMAL BUSINESS HOURS WILL HAVE AN ADDITIONAL FEE THAT IS NOT COVERED UNDER MEDICARE, WORK COMP OR OTHER HEALTH PLANS. THE INDIVIDUAL IS ULTIMATELY RESPONSIBLE FOR THIS ADDITIONAL FEE****

ASSIGNMENT OF BENEFITS

Patient Name: _____ Today's Date: _____

Employer: _____

Group#: _____

SS# of Primary Policy Holder: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

**Tim Melton, DC
4545 Hartford
Abilene, TX 79605**

Should the benefits, under any third party payer plan, whether it be insurance, an employee benefit plan, and ERISA plan, Local, State, or Federal Agency or program be non-assignable for any reason, I hereby specially direct that the third party payer send payment, for any benefits to be paid for care provided to me by Dr. Tim Melton, to my attention at 2074 Antilley Road, Abilene, TX 79606. By sending payment in this manner, I release the third party payer of any liability under the plan or policy, to the extent of the payments made.

For the professional or medical expense benefits allowable, otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photo copy of this Assignment shall be considered as effective and valid as the original.

I also authorize release of any information pertinent to a third party payer should the facility believe it is necessary to process a claim for reimbursement. This assignment will remain in effect until revoked by me in writing.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at Dr. Melton's Office this _____ day of _____, 20____

Signature of Owner (person who is policyholder)

Witness

Signature of Patient, (if other than Policy Owner) Relationship to Policy Owner

THIS DOCUMENT SHOULD NOT BE ALTERED IN ANY MANNER

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Dr. Melton's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative Authority