

Consent and Authorization for Electronic Claims

This form must be filled out when claims are submitted electronically by Brost Chiropractic & Wellness Centre on the patient's behalf. This form will stay in patient's file for verification purposes. A new form will be required, should patient's benefits change.

Authorization and consent

I authorize Brost Chiropractic & Wellness Centre to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize such insurer and / or plan administrator and their service provider(s) to:

- *use my personal information for the above purposes.*
- *exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits, or other benefits programs, other organizations, or service providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.*
- *where applicable exchange personal information concerning any claims with any assignee of benefits payable and exchange personal information for the above purposes electronically or in any other manner.*

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.

I hereby assign benefits payable for the eligible claims to Brost Chiropractic & Wellness Centre for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to such provider. **In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the healthcare provider for any services rendered and/ or supplies provided.**

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this benefit assignment form, that any benefit payment made in accordance with this benefit assignment form will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by Brost Chiropractic & Wellness Centre and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to Brost Chiropractic & Wellness Centre.

Print Name

Date

Signature of plan member / spouse / dependent _____



Brost Chiropractic & Wellness

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POLICY ON CHIROPRACTIC HEALTH INSURANCE

It is important that you understand that health and accident insurance policies are an arrangement between you and your insurance company. Our office will help you complete any of the necessary forms to ensure prompt reimbursement from your insurance company.

You are personally responsible for all costs incurred in our office.

Please fill out this form and return it to our office at your next visit.

INSURANCE COMPANY: _____

Patient's First Name: _____ Patient's Last Name: _____

Patient Phone Number: _____ Date of Birth: _____ Gender: Male Female

Plan Member First Name: _____ Plan Member Last Name: _____

Group # _____ Mem ID# _____ Plan Member DOB: _____

Relation to Plan Member: _____ Patient Code: _____ Postal Code: _____

Chiropractic limit per year: _____ Max \$ or % payable per treatment _____

Is my Chiropractic combined with other paramedical (massage, physio, acupuncture, etc)? YES NO

Does my policy cover Custom Orthotics? YES NO

Max \$ or % paid per Orthotic _____ Prescription required? YES NO

Prescription by: Chiropractor Medical Doctor Podiatrist Chiropodist

Benefit renewal date: _____