

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from Diamond Sport & Spine Clinic ("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 of Birth

Date

Policyholder/Insured

Date

**HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION**

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information. Please read it carefully before signing.

Diamond Sport & Spine Clinic will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.**

By signing this authorization you acknowledge and agree that Diamond Sport & Spine Clinic may use or disclose any health care related documentation for the purpose(s) of treatment or management of the patient's health.

By signing this authorization you agree that Diamond Sport & Spine Clinic or its Business Associates may disclose your personal health care information to a requesting entity or health care provider.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Diamond Sport & Spine Clinic's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Diamond Sport & Spine Clinic has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Diamond Sport & Spine Clinic at any of its offices or by sending a written request with return address to 1426 N. Clayton St. Wilmington, DE 19806.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Diamond Sport & Spine Clinic for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Diamond Sport & Spine Clinic has taken action in reliance on it. A revocation is effective upon receipt by Diamond Sport & Spine Clinic of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Diamond Sport & Spine Clinic, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Diamond Sport & Spine Clinic will provide _____ [name of patient] with a copy of this signed authorization at his or her request.

Acknowledged and agreed to by:

Patient Name: _____

Patient Signature: _____

Date: _____

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy, etc. on me by all licensed doctors, associates, or assistants of Diamond Sport & Spine Clinic.

I understand, as with any health care procedure, there are certain complications which may arise during or after treatment. Those complications include but are not limited to: fractures, disc injuries, dislocations, sprain/strain injuries, soreness, and costovertebral strains and separations. Some types of neck manipulations have been associated with injuries to the arteries of the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the care which the doctor feels at the time, based upon the facts then known that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatment. I state that I have been informed and weighed the risks and benefits involved with chiropractic care at this office. I have decided that it is in my best interest to receive treatment at Diamond Sport and Spine Clinic. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s), and for any future condition(s) for which I seek treatment.

Patient/Representative Name: _____

Patient/Representative Signature: _____

Date: _____