ASSIGNMENT OF BENEFIT
INSTRUCTIONS AND
AUTHORIZATION AND RELEASE

AUTHORIZATION AND RELEASE: I authorize direct payment of insurance benefits go to the office of Ewing Chiropractic, LLC or Dr. Porcia Ewing, D.C. I authorize the doctor to release all information pertinent to my case necessary to communicate with personal physicians and other healthcare providers and any insurance company, adjuster or attorney involved in case and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Ewing Chiropractic LLC
Porcia Ewing, D.C.
7147 Jonesboro Rd Ste J
Morrow, Ga 30260
(678)983-0688

as payment for 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. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Ewing Chiropractic LLC
Porcia Ewing, D.C.
7147 Jonesboro Rd Ste J
Morrow, Ga 30260
(678)983-0688

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

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedure concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to

receive your medical records, please inform our office.

Patient's Name (Please Print) :_____

Patient's Signature: _____

Guardian's Name (Please Print): _____

Gauardian's Signature Authorizing Care: _____