Shell Chiropractic & Wellness Center
a natural approach to a healthier you

Dr. June M Shell

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Old Bridge, NJ 08857
(732)607-0842

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

I, request that payment of authorized private insurance benefits or Medicaid be made to Dr. June M. Shell for any covered services furnished by Dr. June Shell. Should payment be sent to you, it is your responsibility to return check to our office within seven (7) days of receipt, Failure to do so will result in civil collection proceedings wherein you agree to pay our reasonable attorneys fees and costs for collection as well as potential criminal liability for theft and conversion of funds. I agree to pay Dr. June M. Shell the deductible and/or copay/coinsurance on my claim.

Please be aware that some and perhaps all services, joint supports or rehabilitative devices which we recommend and/or provide may be considered non covered items, and therefore considered not medically necessary under the Medicare program and other insurance carriers. Therefore, you will be responsible for the payments.

By signing this form, you are granting consent to June M. Shell, DC to use and disclose your protected health information for the purposes of treatment, payment, health care operations and those people listed below. You further assign your rights to benefits under your contract of insurance or other third party payment to June M. Shell, DC and its employees, agents and/or contractors, all benefits payable to you under your insurance policies and health benefits plans. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I hereby designate, authorize and convey to June M. Shell, DC to the full extent permissible under law to under applicable insurance policy and/or health care benefit plan to act on my behalf in connection with or pursuit of any claim, right or choice in action that I may have under such insurance policy and/or any employee health care benefit plan.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this related Medicare or Medicaid claim.

Disclosure information to:

X_____ _____ _____
PRINT PATIENT'S NAME DATE NAME PHONE #

X_____ _____ _____
PATIENT'S SIGNATURE DATE NAME PHONE #

X_____ _____ _____
OTHER THAN PATIENT, PRINT NAME AND RELATIONSHIP NAME PHONE

X_____ _____ _____
WITNESS NAME PHONE #