Assignment and Instruction for Direct Payment to Doctor Private and Group Accident and Health Insurance

Patient's Name:___ _____
Employer: _____
Claim/Group: _____
SS# or ID#: _____

I hereby authorize and direct payment for services rendered to me to be made payable to **Pure Wellness**.

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.

I understand that it is my responsibility to know my benefits and I understand that Pure Wellness will act on my behalf to obtain payment for services rendered to me.

I understand that it is my decision to receive treatment based on the recommendations of the doctor, and I understand that my insurance company may or may not approve all medically necessary treatments. I understand that I am financially responsible for all charges whether or not paid/authorized by my insurance carrier.

I understand that I am responsible for obtaining any authorizations or referrals for services provided. Failure to do so may result in my being financially responsible for services rendered.

I understand that most health insurance plans DO NOT COVER supplies, supports, vitamins and massage, acupuncture, etc. Such items must be paid for at the time service or upon receipt of the supplies.

I understand that I am responsible to provide PURE WELLNESS with any changes in my health care coverage, my current condition or my personal information. (ex: name change, address, phone#, etc.)

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Pure Wellness will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Pure Wellness will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care that any fees for professional services rendered to me will be due and payable within 30 days.

I authorize the use of my signature on all insurance submissions.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at Pure Wellness this _____ day of _____of 20____

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant if other than policyholder