DR. ALAN P. JUEL

CHIROPRACTIC PHYSICIAN
PHYSICAL THERAPIST

3202-D W. MAIN
RAPID CITY, SOUTH DAKOTA 57702
PHONE: (605) 348-5134 • FAX: (605) 348-6420

PATIENT CONSENT AUTHORIZATION

ASSIGNMENT OF BENEFITS: I hereby assign instruct and direct my insurance company to pay benefits directly to Dr. Alan Juel for professional and medical expenses, otherwise payable to me under my current insurance policy. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

FINANCIAL RESPONSIBILTY: I agree to be financially responsible for all charges incurred at the office of Dr. Alan Juel, including my insurance deductible, co-payment and any services rejected by my insurance company.

RELEASE OF INFORMATION: "This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information. Please review this notice carefully." This office is committed to health information privacy. Dr Alan Juel may disclose all or part of my records to any person or corporation which is or may be liable under a contract to Dr Alan Juel or to the patient or to a family member or employer of the patient for all part or parts of Dr. Alan Juel's charges, including but not limited to insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

MEDICARE AND MEDICAID PATIENT CERTIFICATION – PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment Title XVIII 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. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for Dr. Alan Juel's services. I understand that I am responsible for my health insurance deductible and coinsurance.

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

Print Patient's Name _____ Date _____

Patient's Signature _____

Other than patient, Print name and relationship _____