*High Point Chiropractic Wellness*
*4856 W.Seneca Turnpike*
*Syracuse,NY 13215*
*315-214-8100*

## ***Method of Payment:***

___ Self ___ Insurance (BC/BS) ___Insurance (Other)_____

Insurance Company Name_____

StreetAddress_____

City_____ State_____ Zip_____

Policy No_____ Claim No_____ Group or Plan No_____

**INSURED INFORMATION**

First Name _____Middle Initial____ Last Name _____

Insured's ID No _____ Date of Birth_____

*I, the undersigned, certify that I (or my dependent) have insurance coverage with the above written company and assign directly to Dr. Irum Hussain all insurance benefits, if any, otherwise payable to me to for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.*

Signature: _____ Date: _____

**MY RESPONSIBILITY FOR PAYMENT OF FEES**

I fully understand and agree that I am directly and fully responsible to pay this clinic, in full, for all professional services and/or products provided to myself and members of my family. I further understand and agree that such payment to this clinic is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee. I also agree to pay all reasonable costs of collection, attorney fees and interest at the ANNUAL PERCENTAGE RATE of 21% (1.75% PER MONTH) on any past due balance (over 60 days old). I further understand that the office charges a $20 fee for returned checks. The office reserves the right to charge for appointments canceled without 24 hours notice and for not attending scheduled appointments.

Signature _____ Date ____/____/_____

**NOTICE OF PATIENT PRIVACY RIGHTS**

By signing below, I acknowledge that I have received a copy of the "Notice of Patient Privacy Rights" and a copy will be available for me at the reception desk upon my request. The Health Insurance Portability and Accountability Act ensures a patient's right to privacy regarding Personal Health Information and it is this office's policy to maintain confidentiality to the highest degree.

**Patient/Legal Guardian's Initials: _____**