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: ______