Benefits Assignment Form

Provider:
Dr Shelley Seguin
Synergy Chiropractic & Health Rehabilitation Centre
409 – 3950 14th Ave, Markham, On L3R 0A9

Patient
Name:_____

Address:_____

City/Province: _____

Postal Code: _____

Extended Health Care Insurer _____

Plan Number _____

Certificate/Member ID _____

Authorization and Consent:

- I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider to:
- Use my personal information for the above purposes
- Exchange personal information with any individual or organization including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law. I agree that a photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and tehri service provider (s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud/plan abuse.

In the event that there is an overpayment, I authorize the recover of the full amount of the overpayment from any amount payable under group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and , where applicable my Plan sponsor, for that purpose.

Member initials _____

Benefit Assignment

I hereby assign benefits payable for the eligible claims to the provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator to issue payment directly to the Provider. My credit card information is provided below. In the event that the my claim(s) are declined by the insurer/plan administrator I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided. In the event that my claim(s) are declined I authorize the provider to bill payment directly to my credit card which will be kept on file with the provider.

I understand and agree that the insurer/plan administrator is under no obligation to accept this assignment, that any benefit payment made in accordance with this assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of it's obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by the provider and that I many revoke it at any time by providing written notice to the insurer/plan member.

Member signature: _____

Date: _____

I have provided my credit card number for the provider to keep on file to collect any outstanding amounts that my insurer does not cover. I authorize my provider to bill my credit card for any outstanding amounts.

VISA/MC # _____

EXP _____

Member Initial _____