

PURELIFE CHIROPRACTIC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THE INSURANCE CARRIER AND ASSIGNMENT OF BENEFITS TO PHYSICIAN

COMMERCIAL INSURANCE

I hereby authorize release of medical information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO PureLife Chiropractic.

I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient or guardian _____ **Date** _____

MEDICARE INSURANCE

Beneficiary _____ Medicare # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to PureLife Chiropractic for any services furnished to me by that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature _____ **Date** _____

MEDICARE SUPPLEMENTARY INSURANCE

Beneficiary _____ Medicare # _____

Medigap # _____

I hereby give PureLife Chiropractic permission to ask for Medicare eSupplemental Insurance payments for my medical care.

I understand that _____ (Medicare Supplemental Insurance) needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to _____ (Medicare Supplemental Insurance).

I request that payment of authorized Medicare Supplemental benefits be made either to me or on my behalf to PureLife Chiropractic for any services furnished me by that practice. I authorize any holder of medical information about me to release any information required to determine and pay these benefits to _____ (Medicare Supplemental Insurance).

Beneficiary Signature _____ **Date** _____