ASSIGNMENT OF BENEFITS/ERISA AUTHORIZED REPRESENTATIVE FORM
Ogle Chiropractic and Rehab Center, LLC

Financial Responsibility

I have requested professional services from Ogle Chiropractic and Rehab Center, LLC Dr. Tabitha Ogle on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advice.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to the said Dr. Tabitha Ogle. I certify that the health insurance information that I provided to Dr. Tabitha Ogle is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Dr. Tabitha Ogle to submit claims, on myself and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Dr. Tabitha Ogle, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Dr. Tabitha Ogle directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Dr. Tabitha Ogle, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Dr. Tabitha Ogle upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Dr. Tabitha Ogle.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Dr. Tabitha Ogle are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Dr. Tabitha Ogle to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatment: (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Dr. Tabitha Ogle to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I receive from Dr. Tabitha Ogle and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Print Date

_____ _____

Policyholder/Insured Signature Date

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZED REPRESENTATIVE FORM
Ogle Chiropractic and Rehab Center, LLC

Financial Responsibility

I have requested professional services from Ogle Chiropractic and Rehab Center, LLC Dr. Shane Ogle on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advice.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to the said Dr. Shane Ogle. I certify that the health insurance information that I provided to Dr. Shane Ogle is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Dr. Shane Ogle to submit claims, on myself and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Dr. Shane Ogle, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Dr. Shane Ogle directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Dr. Shane Ogle, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Dr. Shane Ogle upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Dr. Shane Ogle.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Dr. Shane Ogle are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Dr. Shane Ogle to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatment: (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Dr. Shane Ogle to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plain (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I receive from Dr. Shane Ogle and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

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Patient Print Date

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Policyholder/Insured Signature Date