

**RUGANI FAMILY CHIROPRACTIC, P.C.**

1733 Route 9, Clifton Park NY 12065

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

***The Non-Medicare Patient***

I hereby assign to Rugani Family Chiropractic, P.C. any and all benefits from any insurance plans or any other protection maintained by the Patient and/or for the Patient's behalf or benefit and authorize and direct such benefits to be paid directly to Rugani Family Chiropractic, P.C. for services provided to the Patient by Rugani Family Chiropractic, P.C.. I certify that the information given by me to Rugani Family Chiropractic, P.C. in applying for payment under Medicare, insurance plans, or other protection is correct and complete. I authorize release of all records required to act on this release and assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

***The Medicare Patient***

I request that payment of authorized Medicare benefits be made to me or on my behalf to Rugani Family Chiropractic, P.C. for any services furnished me by that provider. 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 benefits or the benefits payable for related services. I certify that the information given by me to Rugani Family Chiropractic, P.C. in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_