



Dr. Robert Benningfield D.C.
Dr. Jessica Benningfield D.C.

ASSIGNMENT OF HEALTH BENEFITS

The parties appearing below, on this date, hereby agree to the following conditions, covenants and terms regarding the assignment of health benefits appearing in my policy issued by me insurance company, if applicable.

I, hereafter referred to as "patient", understand and voluntarily agree to assign all applicable health provisions pertaining to payments or benefits appearing in my insurance policy, if applicable, in consideration for treatment rendered by Dr. Benningfield, hereafter referred to as "Doctor". That Patient, the policy holder, requests, orders and directs my insurance company, if applicable, to pay Doctor Directly to his/her office at 2785 Charlotte Hwy, Suite 23; Mooresville, NC 28117, the sum due Doctor for treatment rendered for my condition.

That Patient gives Doctor the exclusive right to secure the funds assigned the patient, including the right of securing counsel to represent the Doctor in collecting all sums due for treatment rendered. That Doctor and Patient hereby enter into this assignment of benefits freely and voluntarily and evidenced by the signatures appearing below. That Patient and Doctor warrant that they have read this assignment of benefits and that each understand the legal effect of the same, and agree that each shall be bound by the covenants, terms and conditions appearing herein.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

NOTICE OF PRIVACY PRACTICES

I acknowledge that Dr. Benningfield's "Notice of Privacy Practices" has been volunteered to me. I understand I have a right to review Dr. Benningfield's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations at Dr. Benningfield's office.

Dr. Benningfield reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or ask for one at the time of my next appointment. I have the right to revoke this consent, in writing, except to the extent that Dr. Benningfield has taken action in reliance on this consent.

Patient _____

Doctor _____

Date _____

Witness _____