# Vermont Chiropractic & Sports Therapy

Dr. Travis M. Hart – Dr. Sarah Harkins Hart
22 Commerce St. Unit 8A – Hinesburg, VT 05461

## AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize________________________________________ Insurance Company to pay by check mailed out and mailed directly to Vermont Chiropractic & Sports Therapy 22 commerce St. Unit 8A Hinesburg, VT 05461, the medical expense benefit allowable, and otherwise payable to me under my current insurance policy, as payment towards the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

### BILLING FOR SERVICES RENDERED

Vermont Chiropractic & Sports Therapy is currently contracted with the following insurance companies:
BCBS of Vermont/The Vermont Health Plan (TVHP) and CIGNA, Great West Healthcare, Landmark/MVP ,
Medicare and Medicaid/VHAP.

**Your health is your responsibility.** If the care is not covered, you will be responsible for the cost. Our office will call to verify your insurance benefits before treatment is rendered. If you have billing questions, you may call our office. **Please be advised that although we offer a billing service free of charge to you as a courtesy, your count balance is essentially your responsibility.**

*Nutritional supplements are not covered by health insurance at this time.

### RELEASE OF PROTECTED HEALTH INFORMATION/HIPAA

By signing this form, you are granting consent to Dr. Travis M. Hart, Dr. Sarah Harkins Hart and/or Vermont Chiropractic & Sports Therapy to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at 802-482-4476. You have a right to request us to restrict how we use and disclose your protected health information. We are not required by law to grant your request. However, if we do grant your request, we are bound by our agreement. You have a right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your request.

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

I have received a copy of the office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and accreditation.