Eckert Wellness Center

Clark Eckert, DC & Tracy Payne, FNP-C

Date: _____ Name: _____

Home Phone: _____ Cell Phone: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Birth Date: _____ Age: _____

Gender: _____ Marital Status: _____ Occupation: _____

Employer: _____ Office Phone: _____

In case of emergency, whom should we contact? _____

Relationship: _____ Phone: _____

Family Medical Doctor: _____ Phone: _____

Insurance Provider: _____

May we have permission to send your notes to your Primary Care Provider? YES NO

How did you hear about our office? _____

Authorization to File Insurance

I authorize Eckert Wellness Center (EWC) to release any information it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered me by EWC or any member of the staff acting on EWC's behalf.

Assignment of Benefits

I authorize the direct payment to EWC of any sum I now or hereafter owe EWC by any insurance company obligated to reimburse me and by my attorney, out of the proceeds of any settlement of my case for the charges for services rendered or otherwise obligated to make payment to me or EWC, based in whole or in part upon the charges made for services rendered. In the event any insurance company obligated by contractual agreement to make payment to me or to EWC for the charges made for services rendered refuses to make such payment upon demand by EWC, I hereby assign and transfer to EWC the cause or action that exists in my favor against any such company. I authorize EWC to prosecute said action either in my name or the name of EWC as EWC deems necessary. I further authorize EWC to compromise, settle, or otherwise resolve said claim as EWC deems necessary.

ERISA Authorization

I hereby designate, authorize and convey to EWC to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized representative: (1) the right and ability to act on my behalf 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 on my behalf 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 to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. 2560.5031 (b)(4) with respect to any healthcare expense incurred as a result of the services I received from EWC 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.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____