WESTHILLS CHIROPRACTIC
MASSAGE AND SPORTS THERAPY
MOVE BETTER FEEL BETTER LIVE BETTER

# Consent to Collect and Exchange Personal Information
(Turn Page Over for Larger Font)

**Message to the Plan Member, Spouse and/or Dependent regarding Personal Information**

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service providers(s) for the purpose of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

**Authorization and Consent**

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service providers(s) for the above purposes.

I authorize the insurer and/or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.

**Benefit Assignment Form:**

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefits payments to the Provider.

| PRIMARY COVERAGE | | SECONDARY COVERAGE | |
|---|---|---|---|
| Insurance Company | | Insurance Company | |
| Name on Policy | | Name on Policy | |
| Policy Number | | Policy Number | |
| Member ID Number | | Member ID Number | |
| Date of Birth | | Date of Birth | |

Patient Name: _____

Patient Signature: _____ Date: _____

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## Benefit Assignment Form:

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