



Assignment of Benefits and Release of Information

HEALTH COVERAGE INFORMATION

Primary Health Insurance	Secondary Health Insurance (if any)
Insurance Company: _____	Insurance Company: _____
Member / ID No.: _____	Member / ID No.: _____
Group No.: _____	Group No.: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Birthdate: _____	Subscriber Birthdate: _____
Patient Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Patient Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____

AUTO / WORKERS' COMPENSATION CLAIM INFORMATION

Date of injury: _____ **Attorney (if applicable):** _____

<input type="checkbox"/> 1st Party Auto <i>Your auto insurance</i> Claim no.: _____ Auto insurer: _____ Personal Injury Protection: <input type="checkbox"/> I have PIP/Med Pay on my policy	<input type="checkbox"/> 3rd Party Auto <i>Other party's auto insurance</i> Claim no.: _____ Other insurer Co.: _____ If no PIP or after PIP is Exhausted: <input type="checkbox"/> Bill my Health Ins -OR- <input type="checkbox"/> Wait for Settlement	<input type="checkbox"/> Workers' Comp / L&I Claim no.: _____ Employer: _____ Claim manager: _____ My Employer is insured with: <input type="checkbox"/> WA LNI -OR- <input type="checkbox"/> Self Insured Worker Comp
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ASSIGNMENT, RELEASE, AND FINANCIAL RESPONSIBILITY

- **Certification and assignment.** I certify that I, and/or my dependent, have the coverage or claim listed on this form. I assign directly to Valente Chiropractic PLLC, its treating providers, and/or its assignees all insurance, claim, and other benefits payable for services rendered. I request that payment be made directly to Valente Chiropractic PLLC to the extent allowed by the applicable plan, policy, or law.
- **Financial responsibility.** I understand that I am financially responsible for all charges not paid by insurance or another payer, including any deductibles, co-payments, co-insurance, non-covered services, denied claims, or amounts that exceed available benefits.
- **Release/use of information for claims and payment.** I authorize Valente Chiropractic PLLC to use and disclose the minimum necessary medical, billing, and claim information to insurance companies, claim administrators, attorneys, and their agents as needed to verify benefits, submit and process claims, coordinate benefits, obtain payment, pursue appeals, and determine benefits payable for related services.
- **Signature on file.** I authorize Valente Chiropractic PLLC to use my signature on file for Box 12 and Box 13 of paper or electronic health insurance claim forms, including authorization to release information necessary to process claims and to direct payment of medical benefits to Valente Chiropractic PLLC.
- **UCC / lien notice.** To the extent permitted by applicable law, I understand that Valente Chiropractic PLLC may file a UCC financing statement, lien, or other notice to seek direct payment from the listed insurance companies or claim payers. Such filing may be searchable as a public record and may include the minimum necessary information, such as my name, address, claim number, amount owed, payer name/address, and this assignment/release.
- **Changes in coverage or claim status.** I understand that if I open or re-open a claim, change insurance, or my coverage changes, I may need to complete a new assignment and release form.

SIGNATURE

By signing below, I agree to the terms above. If signing for the patient, I confirm that I have authority to act as the patient's parent, guardian, or personal representative.

Signature: _____ Date: _____

Printed Name: _____ Relationship/Authority, if not patient: _____