VALENTE
CHIROPRACTIC
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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: ☐ Self ☐ Spouse ☐ Child ☐ Other _____	**Patient Relationship to Subscriber:** ☐ Self ☐ Spouse ☐ Child ☐ Other _____

☐ **Veterans:** Some or all my services may be covered under an approved VA CCN / TriWest authorization. I authorize Valente Chiropractic PLLC to submit claims and receive payment directly for VA-authorized services, subject to the applicable authorization and VA/TriWest program rules. **Veteran ICN:** _____ **Name:** _____ **DOB:** _____

AUTO / WORKERS' COMPENSATION CLAIM INFORMATION

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

☐ 1st Party Auto	☐ 3rd Party Auto	☐ Workers' Comp / L&I
Your auto insurance	*Other party's auto insurance*	Claim no.: _____
Claim no.: _____	Claim no.: _____	Employer: _____
Auto insurer: _____	Other insurer Co.: _____	Claim manager: _____
Personal Injury Protection:	**If no PIP or after PIP is Exhausted:**	**My Employer is insured with:**
☐ I have PIP/Med Pay on my policy	☐ Bill my Health Ins **-OR-** ☐ Wait for Settlement	☐ WA LNI **-OR-** ☐ Self Insured Worker Comp

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.
- **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: _____