GALLI FAMILY CHIROPRACTIC

ACKNOWLEDGEMENT RECEIPT OF PRIVACY NOTICE

As you know, Galli Family Chiropractic is committed to maintaining your privacy. Additionally, the federal government has adopted new laws regarding the privacy of protected health information (phi) by which certain health care providers, including Galli Family Chiropractic are required to abide by. One of these requires that we provide you with the attached **NOTICE OF PRIVACY PRACTICES**. This **NOTICE** explains how we use and disclose your protected health information. It also explains your rights to the use and disclosure of your protected information.

My signature below acknowledges receipt of Galli Family Chiropractic **Notice of Privacy Practices**. I also understand that prior consent to release information is not required for specific uses or disclosures of the release of protec6ted health information according to the terms of Galli Family Chiropractic's **Notice of Privacy Practices.**

_____ _____

Signature Date

109 FALLS COURT SUITE 500 BOERNE, TEXAS 78006 PHONE # 830-249-7858

Galli Family Chiropractic, PA
109 Falls Court #500 Boerne, Texas 78006

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Carlo D. Galli, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me / us for treatment rendered by the physician facility named above, you are hereby tendered demand to pay in full the bill of services rendered by the physician / facility named above within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Functional Galli Family Chiropractic and to send all checks to 109 Falls Court Suite #500 Boerne, Texas 78006.

THIRD PARTY LIABILITY: If my injuries are a result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, directly to Galli Family Chiropractic of Boerne, TX 78006.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician / facility named above, in addition to to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician / facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician / facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my / our account or forwarded to my / our address upon request in writing to the physician/ facility named above.

REJECTION IN WRITING: I hereby authorize the physician / facility named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the physician / facility named above, any rejections in writing as they apply to my lack of PIP or UM / UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to physician / facility named above, and to send any and all other checks or financial instruments to 109 Falls Court Boerne, TX 78006.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this facility, he / she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other physician, this physician / facility immediately. I understand that failure to do so may jeopardize my case.

Signature of patient and / or responsible parties:

_____Date_____