

**Chiropractic, Acupuncture & Massage Center**  
**Dr. Amir Ahmadiyar, D.C.**  
*Your Back to Health Choice for All Ages*

Authorization to Pay Physician

I hereby authorize \_\_\_\_\_ Insurance Company to pay by check and mail directly to:

**Greater Falls Church Chiropractic Center**  
**6521 Arlington Boulevard, Suite 100**  
**Falls Church, VA 22042**

**Ashburn Chiropractic Center**  
**44121 Harry Byrd., Suite 145**  
**Ashburn, VA 20147**

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it to the above named address for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

# CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

DR. AMIR AHMADIYAR, D.C.

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## Confidential Health History

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Female: \_\_\_\_\_ Male

SS#: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Employment Status: \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Not Employed \_\_\_\_\_ Retired \_\_\_\_\_

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced \_\_\_\_\_ Separated: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse SS#: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\*\*\*\*Referred to this office by: \_\_\_\_\_

### PLEASE CIRCLE TYPE OF PATIENT:

SELF PAY    INSURANCE    AUTO ACCIDENT    WORKER'S COMP

### HEALTH INSURANCE INFORMATION

**Primary Insurance:** \_\_\_\_\_

Policy Holder: Self    Spouse    Other \_\_\_\_\_

ID#: \_\_\_\_\_

Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS #: \_\_\_\_\_

Sex: \_\_\_\_\_ Male    \_\_\_\_\_ Female

**Secondary Insurance:** \_\_\_\_\_

Policy Holder: Self    Spouse    Other \_\_\_\_\_

ID#: \_\_\_\_\_

Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS #: \_\_\_\_\_

Sex: \_\_\_\_\_ Male    \_\_\_\_\_ Female

\*\*\*\*\*  
**I understand and agree that health and accident insurance policies are an arrangement between insurance carriers and my self. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized should be paid directly to the Doctor's Office will be credited to me account on receipt. However, I clearly understand and agree that services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In the event my account is past due for 60 days from the date of service, and is turned over to an attorney for collection, I will also be liable for attorney's fees in the amount 1/3 of the principal balance, plus court costs.**

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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**Designation of Authorized Representative**

I \_\_\_\_\_, do hereby designate Dr. Amir Ahmadiyar/ Dr. James Geer of Greater Falls Church Chiropractic Center to full extent permissible under the Employee Retirement Income Security Act of 1974 (“ERISA”) and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other healthcare expense(s) incurred as a result of the services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical plan reimbursement and to pursue any other applicable remedies.

\_\_\_\_\_  
Patient’s Name

\_\_\_\_\_  
Patient’s Signature

\_\_\_\_\_  
Date



# CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

Dr. Amir Ahmadiyar, D.C.

## Notice of Practices Acknowledgement

I understand that, under the Health insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

\*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

\*Obtain payment from third party payers.

\*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_

**CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER**  
**Dr. Amir Ahmadiyar, D.C.**

**Office Financial Policy**

Please be informed of the following office financial policy:

\_\_\_\_\_ **I am a Cash/Self-Pay Patient**

- I am responsible for all charges incurred for my treatment during each of my visits.
- I will get a 10% discount fee if I pay for **10** consecutive visits in advance.
- Birthday Rule: I get a 50% discount if I bring my birthday postcard sent to me by the office on my birthday month.
- Complimentary Referral Rule: I get a choice of a free visit or a free ½ hour massage if I refer someone to the clinic and is seen by my doctor.

\_\_\_\_\_ **I am an Insurance/Medicare Patient**

- I am agreeing to pay my co-payment at the time of each service.
- I am responsible and will be billed for my insurance deductible and coinsurance as reflected on my EOB(Explanation of Benefits)
- I am responsible to obtain any referrals needed prior to my visit from my insurance company or primary care physician's office. If seen without a referral, I agree to be financially responsible for all charges incurred for all services rendered.
- Birthday Rule: My co-payment is waived at the time of service if I bring my birthday postcard sent to me by the office on my birthday month.
- Complimentary Referral Rule: I get a choice of a free ½ hour massage or my co-payment being waived for one visit if I refer someone to the clinic and is seen by my doctor.

**Acknowledgement**

- I understand that payment is expected when services are rendered unless other arrangements have been made.
- I understand that I will be financially responsible for the recommended care whether or no the anticipated results and benefits are achieved.
- I understand that I will be billed directly for the \$20 Fee for massage cancellation done less than 24 hours notice.
- In the event that my participation with my healthcare network is terminated, I wish to continue my treatment as a private paying patient and I would be personally responsible for the charges associated with my care.
- If outside collection services or attorneys are employed by this facility for the individual who disregards our office policy, he/she agrees to pay those charges, including court costs and attorney fees of 33+1/3% in the event this file is turned over to an attorney for collection.

\_\_\_\_\_   
Patient Name

\_\_\_\_\_   
Date

\_\_\_\_\_   
Signature