Restore Chiropractic & Wellness Centre
Dr. Leon Paschalidis, D.C.
241 West Street, Unit 3
Orillia, Ontario L3V 5C9
Telephone: 705.325.0832 Fax: 705.325.8401

Electronic transmission authorization and consent form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider		
First Name Dr. Leon	Last Name Paschalidis	
Address 241 West Street North, Unit 3		
City Orillia	Province Ontario	Postal Code L3V 5C9

Patient		
First Name	Last Name	D.O.B
Primary coverage insurer/payer		
Primary coverage plan member name	Primary coverage plan member D.O.B	
Primary coverage policy number (also referred to as group or contract number)		
Primary coverage certificate (also referred to as member/identification number)		

Do you have secondary coverage? Yes No

Secondary coverage insurer/payer	
Secondary coverage plan member name	Secondary coverage plan member D.O.B
Secondary coverage policy number (also referred to as group or contract number)	
Secondary coverage certificate (also referred to as member/identification number)	

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Consent to collect and exchange personal information

Purpose

Personal information that we collect and disclose about you, and if applicable, is used by the insurer, and/or plan administrator of your group benefits plan, its affiliates and their service provider(s) for the purposes of assessing eligibility for your claims, underwriting, investigating, auditing and otherwise administering the group benefits plan, including the investigation of fraud and / or plan abuse and for internal data management and data analytical purposes.

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 provider(s) for the above purposes.

I authorize such 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, other organizations, or service providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.
- where applicable exchange personal information concerning any claims with any assignee of benefits payable and 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 understand that my healthcare provider will submit my claim on my behalf only after I complete my payment, either by prepayment or at the time of service. I understand that I will be reimbursed for my payment after my claim has been received and processed.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my employer or benefit plan sponsor, for the purposes of investigation and prevention of fraud and/or benefit plan abuse. I understand that the submission of fraudulent claims is a criminal offense.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my benefit plan sponsor,for that purpose.

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If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above

I accept the terms and conditions

_____ _____

Date Signature of plan member

All information contained herein is protected by privacy laws including the Personal Information Protection and Electronic Documents Act (PIPEDA) and all the corresponding provincial legislation. All users agree to protect the personal health information contained herein from unauthorized use, disclosure, loss, theft, or compromise in accordance with the above noted laws and with at least the same care employed to protect their own confidential information. Any unauthorized access, disclosure or use of this information is illegal.