FINANCIAL RESPONSIBILITIES

Everyday new insurance companies are forming and present companies are changing. To better serve you, we have obtained your basic chiropractic insurance benefits for you. However, it is in no way a guarantee of payment for our services from your insurance company. Consequently, it is impossible for us to know exactly what your insurance company will cover.

Please check with your insurance carrier so you will be aware of your coverage regarding office visits, x-rays, spinal manipulations, etc. It is to your benefit to be well informed to prevent having to pay for a service that may have been covered if you had a referral, prior authorization, second opinion, etc.

If you do not inform us of any insurance changes, you will be responsible for the services rendered.

If your insurance plan does not cover services that are rendered, you will be responsible for those services.

You are responsible for all co-pays and deductibles.

If you have no insurance, you are totally responsible for all services rendered. Talk to us about payment plan arrangements. If you have not made a payment on an outstanding balance within a 30 day period, a service fee of 2% will be added to your account.

I have read the above information and I understand it.

______________________________ ____________

PATIENT'S SIGNATURE (PARENT/GUARDIAN) DATE

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claims.

I hereby authorize Advanced Health Chiropractic to apply for benefits on my behalf for covered services rendered by them or their order. I request the payment from my insurance company to be directed to Advanced Health Chiropractic (or to the party who accepts assignment).

I permit a copy of this authorization to be used in place of the original.

I certify that the information that I have reported with regard to my insurance coverage is correct. I am solely responsible for any errors or omissions I may have made in the completion of this form.

______________________________ ____________

PATIENT'S SIGNATURE (PARENT/GUARDIAN) DATE

ACKNOWLEDGEMENT & UNDERSTANDING

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.

I hereby authorize the doctors and staff affiliated with Advanced Health Chiropractic to treat my condition as deemed appropriate.

Signature of Patient (Patient/Guardian): ______________________________ Date: ____________

PATIENT RECORDS AUTHORIZATION—RECORDS RELEASE & REQUEST

To Advanced Health Chiropractic, I hereby authorize you to release to my Primary Care Physician and/or Specialists any information including the diagnosis and records of treatment or examination rendered to me for all care during the period of the start of care to current. I also authorize release of my health information records to Advanced Health Chiropractic for services (pertaining to condition) rendered during care at my Primary Care Physician's office and/or Specialists.

Signature of Patient: ______________________________ Date: ____________

Signature of Staff: ______________________________ Date: ____________