

Advanced Family Chiropractic

I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Advanced Family Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Advanced Family Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all 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 at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees, if legal action becomes necessary, to collect this account. I authorize Advanced Family Chiropractic to obtain a credit report, if necessary.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature who authorized care _____

IN CASE OF EMERGENCY, PLEASE NOTIFY _____

PHONE _____ **ADDRESS** _____

RELATIONSHIP TO PATIENT _____

MEDICARE PATIENTS ONLY

Medicare pays for services rendered on a medical necessity basis. They may or may not pay up to 36 visits per calendar year for chiropractic care. This is decided after they have reviewed your case. Therefore, we would like you to be aware that they will be basing your care on a medical necessity basis.

I, _____, have read the above paragraph and understand that if Medicare does not find my case a medical necessity, I know that I am responsible for all services rendered.

Signature _____ Date _____