Office Policy

Patient Name: _____

I understand that it is my responsibility to know my insurance policy with regard to physician participation, required referral and covered services by my insurance company.

I am fully aware that it is my responsibility to provide your office with a written referral from my primary care physician if my plan requires one. If I do not present a referral at the time of my office visit, I am responsible for all charges incurred.

I understand also that confirmation of coverage, as well as an authorized referral, does not guarantee payment from my insurance company and that I will be responsible for any charges not covered by my insurance plan.

I agree to pay any co-pays and/or deductibles as per my insurance plan and that if I receive a bill from your office I am required to pay it within a thirty day period. If there is a problem with the charges I will notify your office promptly within thirty days.

I hereby authorize Elite Chiropractic/Therapeutic Rehabilitation to furnish information concerning my illness and treatment to my insurance company, attorney, school or other treating physician. I also hereby assign Elite Chiropractic/Therapeutic Rehabilitation payments for medical service rendered to myself. I understand that I am responsible for any amount not covered by insurance and that Elite Chiropractic/Therapeutic Rehabilitation requires payment at the time of treatment unless prior Arrangements have been agreed upon.

I am fully aware that Therapeutic Rehabilitation/Acupuncture is out of network. Your insurance company may send the checks directly to you. It is your responsibility to sign the back of the check and turn it over to our office. Please include all of the paperwork included with the check. There will be a $75 fee for all missed/no show appointments not canceled within 24 hours. (Massage, Cupping, Physical Therapy, Acupuncture). **If you choose to pay by credit card there is a 3. % convenience fee added to the total.**

_____ _____

Signature of responsible party Date

Patient Liability Agreement

I understand that I am financially responsible for all bills incurred while under the care of Elite Chiropractic/Therapeutic Rehabilitation. In the event that my account is not paid in full, I shall be liable for any and all costs of collection. This includes, but not limited to a 35% fee of outstanding balance if my account is forwarded to a collection agency for collection and/or court action. If my account is forwarded to an attorney for legal proceedings, I agree to be liable for any additional attorney fee making a total collection and attorney fee of 50% of the outstanding balance

I further understand that there shall be a 1.5% interest charge per month on any outstanding balance that is forwarded to collection.

By signing below, I hereby indicate that I have read and understand the terms of this contact:

_____ I understand there will be a 35% fee of outstanding balance if my account is forwarded to a
Initial collection agency for collection and/or court action.

_____ I understand there will be a 50% combined collection and attorney fee if my account is forwarded Initial to an attorney for legal proceedings and/or court action.

_____ I understand there will be a 1.5% interest per month on any outstanding balance that is forwarded
Initial to a collection agency and/or court action.

_____ _____

Signature of responsible party Date

Office Policy

Patient Name: _____

I understand that it is my responsibility to know my insurance policy with regard to physician participation, required referral and covered services by my insurance company.

I am fully aware that it is my responsibility to provide your office with a written referral from my primary care physician if my plan requires one. If I do not present a referral at the time of my office visit, I am responsible for all charges incurred.

I understand also that confirmation of coverage, as well as an authorized referral, does not guarantee payment from my insurance company and that I will be responsible for any charges not covered by my insurance plan.

I agree to pay any co-pays and/or deductibles as per my insurance plan and that if I receive a bill from your office, I am required to pay it within a thirty-day period. If there is a problem with the charges, I will notify your office promptly within thirty days.

I hereby authorize Elite Chiropractic/Therapeutic Rehabilitation to furnish information concerning my illness and treatment to my insurance company, attorney, school or other treating physician. I also hereby assign Elite Chiropractic/Therapeutic Rehabilitation payments for medical service rendered to myself. I understand that I am responsible for any amount not covered by insurance and that Elite Chiropractic/Therapeutic Rehabilitation requires payment at the time of treatment unless prior
Arrangements have been agreed upon.

I am fully aware that Therapeutic Rehabilitation/Acupuncture is out of network. Your insurance company may send the checks directly to you. It is your responsibility to sign the back of the check and turn it over to our office. Please include all of the paperwork included with the check. There will be a $75 fee for all physical therapy appointments not cancelled within 24 hours. There will be a $50 fee for all Acupuncture/Massage therapy appointments not cancelled within 24 hours or a no-show fee. **If you choose to pay by credit card there is a 3.% convenience fee added to the total.**

_____ _____

Signature of responsible party Date

Patient Liability Agreement

I understand that I am financially responsible for all bills incurred while under the care of Elite Chiropractic/Therapeutic Rehabilitation. In the event that my account is not paid in full, I shall be liable for any and all costs of collection. This includes, but not limited to a 35% fee of outstanding balance if my account is forwarded to a collection agency for collection and/or court action. If my account is forwarded to an attorney for legal proceedings, I agree to be liable for any additional attorney fee making a total collection and attorney fee of 50% of the outstanding balance.

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to an attorney for legal proceedings and/or court action.

_____ I understand there will be a 1.5% interest per month on any outstanding balance that is forwarded
Initial to a collection agency and/or court action.

_____ _____

Signature of responsible party Date

Patient Responsibility form

Patient Name:_____ Date:_____

Co-pays:
I understand that I am responsible to pay all co-payment at the time of service, prior to leaving.

Deductible:
If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider.

I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

_____

Patient Signature/Guardian Date

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Elite Chiropractic and Wellness Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Elite Chiropractic and Wellness Center. I understand that diagnosis or treatment of me by Elite Chiropractic and Wellness Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Elite Chiropractic and Wellness Center is not required to agree to the restrictions that I may request. However, if Elite Chiropractic and Wellness Center agrees to a restriction that I request, the restriction is binding on Elite Chiropractic and Wellness Center and Dr. Staci Addessi.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Staci Addessi or Elite Chiropractic and Wellness Center has taken action in reliance on this consent.

My " protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Elite Chiropractic and Wellness Center's Notice of Privacy Practices prior to signing this document. The Elite Chiropractic and Wellness Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Elite Chiropractic and Wellness Center. The Notice of Privacy Practices for Elite Chiropractic and Wellness Center is also provided on the wall. This Notice of Privacy Practices also describes my right and the Elite Chiropractic and Wellness Center's duties with respect to my protected health information.

Elite Chiropractic and Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority