# Consent, Authorization, and Financial Policies

## Vitale Chiropractic
## Please read the terms carefully

**Treatment Authorization:** I consent to treatment for myself and/or on behalf of the minor to which this pertains. I give permission for the doctors and/or assistants of Vitale Chiropractic to examine, x-ray, diagnose, and initiate treatment including manipulation and physiotherapy as deemed appropriate and considered necessary by typical standards of care. I further attest that I am the Legal Guardian of the minor or have the authority to authorize care and treatment. I understand the office policy in the case of separated or divorced parents: the parent bringing the child into the office is financially responsible for all charges incurred if not noted otherwise. This serves as a long-term authorization that applies until revoked.

Name of Patient printed: _____

Signature of Patient/Parent/Legal Guardian: _____

**Payment Authorization:** I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that authorization of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance, worker's comp, auto insurance, third party, my adjustor, or attorney directly to the appropriate physician of Vitale Chiropractic. This assignment will remain in effect until revoked by me in writing. See TCA 56-7-120 (a) (1&2)

Signature: _____

**Financial Policy:** At Vitale Chiropractic, we are committed to providing you with the best possible care regardless of whether you have insurance or not. If your insurance covers chiropractic, we are glad to assist you in receiving your maximum allowable benefits. If not, we have many affordable options for you. We will discuss your treatment options, alternatives, financing, and any other questions to the best of our ability. Doing this up front allows everyone to focus on what is most important: YOUR HEALTH
In order to achieve your health goals, we need your understanding of our payment policies and your insurance's rules. We emphasize that we are health care providers first, not a billing company; our relationship is with you, not your insurance company. While filing of claims is a courtesy we provide our patients, it is not our responsibility to coerce the responsible parties to pay the full benefits to which you are entitled. Each insurance company policy is unique in services covered, amounts allowed for services, as well as the amount you are contracted to pay. Your insurance is a contract between you and your insurance company only; we are not party to that contract You are ultimately responsible for your charges from the date services are rendered. You may also be responsible for what your insurance company, or attorney does not pay in accordance with timely payment laws, or procedures that are routinely covered but rejected as not medically necessary by your policy. Remember, insurance is a method of assistance in paying your doctor but is not a substitute for payment. We accept cash, check, most major credit cards, and allows some short term financing with prior approval**. We DO NOT carry accounts over 90 days.**

**Terms:** Returned checks will be subject to a $20.00 returned check fee. Balances past 90 days (without prior arrangements or notice of circumstances) will be considered in default and may be subject to additional collection fees and interest charges. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Initials X_____ I am aware in the event my account becomes delinquent, I am responsible for all the collection and/or legal fees incurred in the collection process. If I make prior payments arrangements and lapse in payment for 90 days, the arrangement is void and the outstanding balance is due in full.

**Payment options:** Medical insurance Medicare Auto insurance Work Comp Self pay Wellness other_____ *We will contact your carrier to verify your coverage, but until we receive an actual payment, this is only an estimate of what they will pay. If you feel your insurance plan is different from what we quoted, please investigate, and let us know immediately. We are here to help*

Quoted Terms: deductible copay percentage ____OV with estimated pt. cost=total_____or_____for term_____

Payment Choices: weekly biweekly monthly each visit

I agree to pay all charges incurred at the coclusion of each visit or in accordance with the schedule agreed upon above.

Patient Signature_____ Date_____

Witness_____

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