SPINE & SPORTS
CHIROPRACTIC CARE OF CT, LLC

220 Farmington Ave., Farmington, CT 06032
Tel: 860-269-3225 • Fax: 860-269-3227
www.spinesportscare.com

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

PATIENT NAME: _____

Thank you for choosing our practice. We are committed to providing you with quality and affordable health care. Part of our responsibility to you, our patient, is to keep you informed of our financial policies and your potential cost share. Please read the following, ask any questions, and sign. A copy can be provided upon request.

CHIROPRACTIC BENEFITS:
Spine & Sports Chiropractic Care will no longer be informing patients of their insurance benefits. It is your responsibility to know your insurance benefits and if our office participates in the plan. Please call your insurance carrier to verify your chiropractic benefits and whether Spine & Sports participates with your plan.

- Depending on your plan, there may be a deductible, a co-pay, or a co-insurance. You are responsible for any co-insurance, deductibles, or non-covered services as required by your insurance company. Insurance plans with which we contract require that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice as it is a requirement placed on you by your insurance carrier. Any remaining balance is due upon receipt of your first statement.
- There may also be a limit on the number of visits per year your insurance plan allows. If you do have a limited number of visits be sure to know if those visits apply to Calendar year or Plan year. We are not responsible to inform you ahead of time if there are any limits as to the number of visits your insurance allows.
- Some insurances require Spine & Sports Chiropractic Care to get authorization before they will apply the service towards the patient's benefits for payment. This means that the insurance will approve or deny your doctors' request based on whether they feel it is medically necessary. Authorization is done by a separate company which your insurance hires to run the authorizations. If you get authorized visits it means that the insurance feels that it is medically necessary for you to receive treatment on that day. The bill is then sent to your insurance and at that point they will see if the patient has the benefits for that claim to be paid.
- Insurance benefits quoted by your insurance company are NOT a guarantee of payment or coverage.

MEDICARE:
Medicare does not cover the fee for any exam, therapy, maintenance care, supports, or supplements. You are responsible for this fee and it is payable at the time of service. If your secondary insurance policy pays for these services, we will then refund your payment.

PATIENTS WITH NO INSURANCE:
Patients without insurance are required to pay in full at the time of service. If you are unable to pay your balance in full, your appointment may be rescheduled until proper arrangements have been made. We are happy to discuss payment options prior to service.

DELINQUENT ACCOUNTS:
In order for Spine & Sports Chiropractic Care to service your account or to collect amounts owed, Spine & Sports may contact you using the contact information provided with your account. Delinquent accounts may be assigned to a collection agency. Failure to pay a delinquent account could result in refusal to schedule appointments for you, your dependents, and/or possible termination from the practice.

CANCELLATION POLICY:
Please inform us at least 24 hours prior to your appointment if you need to cancel or reschedule your appointment. Failure to present at the time of your visit or give a 24-hour advance cancellation notice may result in a "No Show" charge of $25.

By signing below, I authorize the following:

- **I authorize this office to release any information concerning my diagnosis and medical records about any treatment or evaluation rendered to me or my dependent during the period of care to third party payers and/or health practitioners. I authorize and request my insurance company to pay the doctor directly for insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service.**

By signing below, I understand the following:

- **I understand that I am responsible to know what my insurance benefits are for chiropractic.**
- **I understand I may have a deductible, co-pay, and co-insurance and if it is not collected at the time of service I will be billed.**
- **I understand that I am responsible for payment of all services rendered to me or my dependents.**
- **I understand that there may be a limit on the total number of visits my insurance will allow each year and if I go over that amount I will be responsible for the entire charge for that date of service.**
- **I understand that authorized visits are different than my total yearly benefits and the insurance may authorize visits that may not be paid because benefits have been exhausted.**

X_____ _____

Patient Signature (Parent/Guardian if patient is a minor) **Date**