**Financial Agreement:**

I agree to pay for services rendered according to Hazel Dell Sports Med & Rehab Clinic DBA Forgey Sports Med & Rehab Clinic’s rates and terms of the physicians or organizations furnishing the services. I understand that I am responsible for charges not covered by my insurance which may include, non- covered services, deductible, co-pays and coinsurance. All accounts are due and payable at the time services are rendered unless prior arrangements have been made with Hazel Dell Sports Med & Rehab Clinic DBA Forgey Sports Med & Rehab Clinic staff. When it comes to treatment of a depended child, I understand I am liable for payment. It will be up to me to obtain reimbursement. I authorize payment directly to Hazel Dell Sports Med & Rehab Clinic DBA Forgey Sports Med & Rehab Clinic and/or health care provider(s) of all insurance or health plan benefits. I understand that Hazel Dell Sports Med & Rehab Clinic DBA Forgey Sports Med & Rehab Clinic cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance reimbursement is a contract between me and my carrier, and all services provided by Hazel Dell Sports Med & Rehab Clinic DBA Forgey Sports Med & Rehab Clinic are billed to my insurance as a courtesy. I am responsible for payment of my account within the usual limits of Hazel Dell Sports Med & Rehab Clinic DBA Forgey Sports Med & Rehab Clinic’s Financial Agreement. I have read this financial policy and understand that, regardless of any insurance coverage I may have, I am financially responsible for payment of medical services rendered.

**Patient or authorized person’s signature: I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_**

**Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Privacy Practices:**

The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I have been provided with a copy of the Notice of Privacy Practices. I understand the clinic has reserved the right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_**

**Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_ It is the responsibility of the patient or patient’s representative to know your insurance policy**

**Initial benefits**

**\_\_\_\_\_\_\_\_ Co-pays are due at the time of service as per your insurance contract.**

**Initial**

**\_\_\_\_\_\_\_\_ Chiropractic adjustments and therapy modalities (ice, tens unit, Myofascial) are billed separately**

**Initial**