

LAKE CHIROPRACTIC
3017 PUMP HOUSE ROAD CAHABA HEIGHTS, AL 35243
PHONE: 205.380.0574 FAX: 205.968.5854

FINANCIAL AGREEMENT

In Consideration for services rendered or to be rendered at Lake Chiropractic, I agree and fully understand the following:

1. I authorized the release of any information acquired in the course of my examination and/or treatment necessary for the process of this claim/assignment.

2. I direct payment of medical benefits otherwise payable to me to Lake Chiropractic.

3. I will pay any and all charges known not to be covered by insurance at the time services are rendered.

4. I will deliver to Lake Chiropractic any checks received from an insurance company relative to services rendered within 3 days of receipt of said checks. I also agree that Dr. Lake Franklin be given Power of Attorney to endorse/sign my name on my checks from third party payers for payment of services rendered at this clinic.

5. I hereby understand and agree that examinations, diagnostic tests, chiropractic treatments, therapy, rehabilitation, braces, and other supplies filed to my insurance company may or may not be covered by my insurance carrier. Therefore, I agree to pay for all services rendered regardless if they are deemed medically unnecessary or a non-covered service by my insurance carrier. I understand that the clinic staff makes no representation as to coverage of my insurance and I do not rely on any insurance information conveyed to me by the clinic staff.

6. If my plan required a referral prior to evaluation, treatment or for on-going care, I understand it is my responsibility to obtain the referral and/or authorization in these circumstances. Any claims denied due to non-authorization or non-certification will be my responsibility.

7. I understand and agree that Lake Chiropractic may charge a fee for copying records (\$5 search fee, \$1 per page for the first 25 pages and \$.50 per page after 25, and postage cost if mailing is required) and radiographs (priced at current hospital rate) and missed appointments without 24 hours notice (\$25). I also understand, and agree to pay, a \$25 fee if the doctor sees me after hours (before 8 am, after 6pm, or on weekends).

8. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. However, I understand that this clinic will prepare any necessary reports and forms to assist me in making any claims with my insurance companies and that any amount authorized to be paid directly to Lake Chiropractic, will be credited to my account on receipt. I understand that if a collection procedure is necessary to satisfy my bill, I am responsible to pay said costs, consisting of court, collection and attorney fees.

Signature: _____
Print: _____

Date: _____
Witness: _____