

**Authorization**

I certify that I have answered the above patient information questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child. I authorize this information to be released to third party payers and/or health practitioners, if needed. I request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me.

X \_\_\_\_\_ Date: \_\_\_\_\_

(Signature of Patient or Parent)

**Financial Responsibility**

Payment for services are due at the time services are rendered unless our staff has approved other arrangements in advance. My claims will be filed to my insurance company by Lindsey ChiroPlus as a courtesy. To better serve me as a patient, Lindsey ChiroPlus will call my insurance company to verify my benefits. This is only a "Quote of Benefits" and NOT a guarantee of payment. After claims are submitted to my insurance company, the remaining balance is my responsibility. I agree to be responsible for payment of all services rendered on my behalf or on my dependent's behalf.

X \_\_\_\_\_ Date: \_\_\_\_\_

(Signature of Patient or Parent)

**Cancellation Policy**

A 24 hour notice of cancellation is required for massage therapy OR physical therapy appointments. If a 24 hour notice is not received for my cancelled appointment, I will be charged in full for the appointment scheduled under a personal cash account. For example, the cancellation for a one hour massage therapy session is currently \$75. The cancellation fee is billed only to me and not to my insurance company.

I agree to provide a 24 hour notice of cancellation for massage therapy or physical therapy appointments. I understand that if I do not provide notice, I will be financially responsible for the cancellation fee.

X \_\_\_\_\_ Date: \_\_\_\_\_

(Signature of Patient or Parent)

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_