

CONSENT/HEALTH INSURANCE FORM

PATIENT'S NAME: _____

CONSENT:

I consent to Chiropractic and Physiotherapy treatment at Dr. Singh's office. I know if I have any questions about my care, I should be sure to ask Dr. Singh about them. I know it is up to me to inform Dr. Singh about any health problems or allergies I have. I must also inform Dr. Singh about any drugs and/or medications I am taking.

RELEASE OF INFORMATION:

Our office releases patient health care information for purposes of treatment or payment, or to other health care organization, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payments and benefits.

INSURANCE:

I authorize the staff at Dr. Singh's office to review my insurance coverage with my insurance company. **I understand that my insurance benefits are only a quote of benefits and not a guarantee of payment.** Insurance policies can differ greatly in terms of deductible and percentage for Chiropractic and Physiotherapy care. Because of the variance from one insurance policy to another, we require that the patient be personally responsible for the payment of their deductibles and co-pays. I understand it is my responsibility as a patient to know my insurance coverage. **I agree to pay in full any and all charges not covered by insurance or other benefits, such as electrodes, iontophoresis, and low-level laser.**

ASSIGNMENT OF BENEFITS:

Attached is an "Assignment of Benefits" form we would like you to sign. This form instructs your insurance company to send their payments directly to our office. Please sign all copies of this form.

CANCEL/NO SHOW/LATE POLICY:

If you must cancel your scheduled appointment, a 24-hour notice is required. **Cancels with less than a 24-hour notice and no shows will result in a \$50.00 fee applied to your account.** If you arrive 10 minutes or more late for your appointment, your therapist may not have time to treat you or your therapy time may be reduced.

I certify that any and all information provided by me in furtherance of my application for health care benefits are true. I have read the information on this form. It has been fully explained to me and all of my questions about this form have been answered. I understand its contents.

I have read and agree to the above

Patient's Signature (If 12 years of age or older)

Signature Date

Signature of Patient's Representative

Signature Date