CONNECTICUT chiropractic

Phone: 860.648.2259
Family Wellness Center, LLC
469-D Buckland Road
South Windsor, CT 06074

FINANCIAL POLICY

To help you determine your responsibility for health care expenses, we have prepared the following checklist and policy statement.

1. GENERAL HEALTH CONDITIONS Group health insurance benefits from this policy will apply. **Medicare – Also see Advanced Beneficiary Notice**	2. ACCIDENT (Personal Liability) Injured in an accident (auto or personal) with an attorney representing you against a negligent party. Possible to collect benefits from this case and/or benefits from other insurance.
3. ACCIDENT (Comprehensive Medical) Injured in an accident (auto or personal), there is Comprehensive Medical Benefits (Auto or Homeowner's) insurance to provide payment. May have benefits from this policy and/or benefits from other insurance.	4. WORKER'S COMPENSATION Injured in the course of employment and eligible to have expenses covered under Worker's Compensation.

INSURANCE: ______________________ ATTORNEY: ______________________

This office is willing to wait for payment of services (supplies, equipment and missed appointment charges are excluded) when you (patient or guardian of the patient) agree to the following conditions.

ASSIGNMENT, AUTHORIZATION, POWER OR ATTORNEY AND AGREEMENT

I agree to provide the office with information regarding my source of payment, to assist in any way I can and:

1. I understand that if there is no third party reimbursement available, all fees are due when service is rendered unless other arrangements have been made in advance of service.
2. I hereby assign to this office my rights to receive payments from negligent or other parties. Payments should be payable to:
   Connecticut Chiropractic
   Family Wellness Center
   If my policy prohibits assignments, then checks should be payable to me and sent to the above address.
3. I understand that if this office receives more than their fees, the office will pay or credit balance to the PATIENT.
4. I authorize the release of information (with valid release of records) to any third party to assist in the payment of the claim.
5. I appoint this office as attorney-in-fact, to correspond on my behalf with third parties, to negotiate any settlement and to cash any settlement draft of check related solely to the health care and office administration services provided by this office. Counsel insurance companies and negligent parties will be advised that no settlement can be effectuated without the agreement of this office or the office's release of this specific provision. Said negotiation to be for the payment of this office's health expenses and will not release negligent parties, attorneys or insurance companies from settling any financial relations with me without fulfilling my financial responsibilities to this office first. This office is to be immediately notified by certified mail if any change to this agreement is made by any other means by any other party.
6. I fully understand and agree that insurance policies are an arrangement between and insurance carrier and me and/or the doctor and insurance company. I will be responsible for any expense not paid by insurance and determined to be my responsibility.
7. If the office incurs attorney fees or other expenses for the collection of this account because I have not complied with this agreement, I understand that I will be responsible for those fees or expenses in addition to the health care fees.
8. A photocopy of this form shall be as valid as the original.
9. I shall make payment immediately for any missed appointment when the office is not provided notice within 24 hours.

___/___/___ ______________________ ______________________
Date **Patient Name** **Signature**

______________________ ______________________
Witness Name **Signature** **Responsible Party Name** **Signature**