NIAGARA FAMILY CHIROPRACTIC PATIENT AUTHORIZATION FORM

AUTHORIZATION OF TEXT MESSAGING I authorize Niagara Family Chiropractic to send text messages to my cell phone. I understand that text messaging rates will apply to any messages received from Niagara Family Chiropractic. I agree not to hold Niagara Family Chiropractic liable for any electronic messaging charges or fees generated by this service. Your information will not be shared or distributed in any way.

Cell Number __________________

24 HOUR NOTICE REQUIRED FOR CANCELLED APPOINTMENTS By signing below your agree that you will be personally responsible for all missed appointments at a charge of $25 per missed appointment.

USE AND DISCLOSURE OF HEALTH INFORMATION I hereby authorize Niagara Family Chiropractic to use and disclose my protected information for treatment, payment and healthcare operations.

This authorization acknowledges that my protected health information may be used and disclosed by my physician, Niagara Family Chiropractic office staff, and others outside of this office that are involved in my care and treatment, for the purpose of providing health care services to me.

AUTHORIZATION FOR RELEASE OF RECORDS This authorization will permit you to furnish a copy of the health records, notes and medical information in your possession regarding my condition while under your observation or treatment including the history obtained x-rays and physical finding, diagnosis and prognosis. I hereby take full responsibility for these records received by your office.

PATIENT NOTIFICATION OF FINANCIAL RESPONSIBILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-pays, deductible, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges which may not be approved. The insurance company will review and/all documentation submitted by Niagara Family Chiropractic for review for medical necessity and base their approval/denial upon this documentation. Insurance policy limitations as per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc. I understand that some policies do not cover routine maintenance, prevention or wellness visits.

I understand that this office agrees to notify me if a service is not covered and will notify me if my care is not approved by the insurance company as soon as possible. If a treatment plan is approved, this office will make me aware of the number of office visits allowed. Initial visits may be denied and this may be beyond the offices ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company. This office may seek payment for you for any services your health insurance plan determines to be not medically necessary.

I have read and understand my obligations for payment for care in the absence of insurance coverage. Failure to pay will make you responsible for any interest fees, lawyer fees, court costs incurred.

Signature of Patient: ____

Date ____