COLUMBIA FAMILY CHIROPRACTIC

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

Patient Name: _____

In consideration of the services that have been or will be rendered to the above patient, I agree to pay for treatment and services performed at Columbia Family Chiropractic.

I understand that I am legally responsible for any and all charges related to the care and treatment provided to me by Columbia Family Chiropractic. I also understand that Columbia Family Chiropractic may file for reimbursement from my insurance company, health plan, or other payer as a courtesy, but failure on the part of the insurance company, health plan or other payer to make payment shall not relieve me of my obligation to pay Columbia Family Chiropractic.

By my signature on this agreement, I assign, and authorize payment be made directly to Columbia Family Chiropractic for all benefits due me under Medicare, Medicaid or any other insurance policy, health plan or from any other payor providing benefits or reimbursement for services rendered by Columbia Family Chiropractic to me and/or my dependents. I must pay all amounts due Columbia Family Chiropractic which are not otherwise paid by my insurance company, health plan, or other payer.

Further, I authorize Columbia Family Chiropractic to disclose, to the extent allowed by law, my medical and financial information as needed for my care, to obtain payment from my insurance provider, health plan or other payer and as needed for Columbia Family Chiropractic to conduct business. These authorized disclosures include, for example, disclosure to (a) my insurance company or health plan or their agents or employees; (b) any person or entity to whom I have been referred by Columbia Family Chiropractic or by my physician for continued care; (c) any physician treating, consulting or otherwise performing medical services for me, including their employees and agents.

In consideration of the services rendered, to the extent not expressly prohibited by law or agreed upon in a contract between Columbia Family Chiropractic and my insurance company and other payer, I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE TO COLUMBIA FAMILY CHIROPRACTIC AT THE USUAL AND CUSTOMARY CHARGE OF COLUMBIA FAMILY CHIROPRACTIC and agree to waive all claims of exemption.

I certify that I am the patient or that I am financially responsible for services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due. A copy or facsimile of this agreement shall be considered as effective and valid as the original.

I HAVE READ THE ABOVE AGREEMENT BEFORE SIGNING IT.

Patient Name: _____ Date: _____

Responsible Party/Guarantor: _____ Date: _____

Relationship to Patient: _____