Craig A. Newman, D.C., P.A.

OFFICE POLICY

Welcome to Our Office
Please read this policy carefully and feel free to ask questions regarding any part of this form. We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of restoring or maintaining your health. If we do not believe your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate. Our practice will strive to provide you with the finest quality chiropractic care. If you have any questions regarding your treatment, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship. **We ask that all cell phones be turned off before you are brought back for your treatment**.

Informed Consent to Chiropractic Care
You hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays. You understand and are informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. You consent to rely on the doctor's judgment and course of action in which he feels is necessary at the time of treatment.

Transferring Records
If you want to have copies of your records, you must authorize us to include all relevant information, including your payment history **upon request**. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information including your payment history. **There will be a $10 copying fee per film for x-rays and 48 hour notice will be required.**

Payment Options
You may choose to pay cash, check or credit/ debit card on the day that the treatment is rendered.

Returned Checks
There is a fee ($25.00) for any checks returned by the bank.

Insurance
Insurance is a contract between you and your insurance company. We will provide you with the service of billing your insurance company for you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by your insurance.**

Verification of Benefits
We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what chiropractic coverage is available on your policy. **You as the policy holder are primarily responsible to verify benefits**. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Workers Compensation
We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury
If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your insurance. In the absence of insurance other financial arrangements may be discussed. We do accept letters of protection, but you will be responsible for paying any fees at the time of your visit until we receive the letter of protection signed by all parties. Payment of any outstanding bill remains the responsibility of the patient.

Required Payments
Any co-payment, deductibles or coinsurance, fees for non-covered services, or outstanding balances must be paid at the time of service.

Payments
Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

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Past Due Accounts
If your account becomes past due, we will take steps to collect this debt. Should your account be more than thirty (30) days delinquent, your balance may be subject to interest charges at a rate of 1.5% per month. Any parent or legal guardian who brings a minor in for treatment is, and hereby agrees to be, responsible for paying the minor's account in full. If we have to refer your account to a collection agency you agree to pay all of the collection of the balance to a lawyer, you agree to pay all the lawyer's fees which we incur, plus all court costs. In case of suit, you agree the venue shall be in Hillsborough County, Florida.

Waiver of Confidentiality
You understand of this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date
Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Signature

Date

Craig A. Newman, D.C., P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the **Notice of Privacy Practices** by the office of Dr. Craig Newman, D.C., P.A. and that I have read (or had the opportunity to read if I so choose) and understood the notice.

_____ _____

Patient's Signature Date

Medical Information Release

I authorize the release of medical information to my insurance company necessary to process my claim. I also authorize the payment of medical benefits directly to my physician. I understand I am financially responsible for charges not covered by this authorization.

_____ _____

Patient's Signature Date

Pregnancy Authorization (For Women Only)

I hereby certify that to the best of my knowledge I am not pregnant and hereby give permission to Dr. Newman or his staff to perform any x-rays he deems necessary. I will not hold Dr. Newman or his staff legally responsible should I find myself to be pregnant.

_____ _____

Patient's Signature Date