

# ACCOUNT & FINANCIAL POLICY

PATIENT'S NAME \_\_\_\_\_

I will be using health insurance to supplement payment       I do not have insurance and agree to be financially responsible

\*RELATIONSHIP TO INSURED:  SELF     SPOUSE     CHILD     OTHER

\*IF YOU CHECKED THE **SELF INSURED** BOX ABOVE, PLEASE **SKIP THIS SECTION** AND READ THE SERVICE AUTHORIZATION AND SIGN AND DATE BELOW. HOWEVER, IF YOUR NAME DOES NOT APPEAR ON THE INSURANCE CARD PLEASE FILL OUT THIS SECTION WITH THE INSURED'S INFORMATION.

INSURED'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

INSURED'S BIRTHDATE \_\_\_\_\_ INSURED'S SEX     MALE     FEMALE

INSURED'S EMPLOYER \_\_\_\_\_

## SERVICE AUTHORIZATION

I understand that if I am accepted as a patient with this office I authorize them to proceed with any care that may be necessary. Furthermore any risks regarding chiropractic care were explained to me and will be further explained upon my request. I hereby consent to the release of any chiropractic or other relevant information necessary to process claims to my insurance on my behalf.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to C.A.F.E. of Life Chiropractic, Inc. or myself will be credited to my account on receipt. However, **I clearly understand and agree that all services rendered to me are charged directly to me whether I use insurance or do not have insurance and that I am personally responsible for payment including my insurance deductible, co-payment, coinsurance and any services rejected by my insurance company.** I also understand that if I suspend or terminate my care and service, any fees for professional services rendered to me will be immediately due and payable. I further agree that should my insurance company fail to remit payment within 60 days or if my current policy prohibits directs payment to the doctor, then I hereby will endorse the paychecks or make payment of my entire balance incurred to C.A.F.E. of Life Chiropractic, Inc. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney(s) involved in this case; and hereby release this office of any consequence thereof. I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by check made out and mailed directly to:

C.A.F.E. of Life Chiropractic, Inc.  
2059 PA Route 309  
Allentown, PA 18104

the professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment according to the financial policy of the above assignee.

**A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I AUTHORIZE THE USE OF THIS FORM AS SIGNATURE ON FILE ON ALL MY INSURANCE SUBMISSIONS.**

I have read and understand the preceding information:

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Dr. Alfonso Di Carlo  
C.A.F.E. of Life Chiropractic, Inc.

\_\_\_\_\_  
Signature of Insured and/or Claimant, if other than insured  
(If practice member is a minor, name of parent/guardian)

\_\_\_\_\_  
C.A.F.E. of Life Chiropractic, Inc. (Signature)

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Tax ID# 23-3066485