Barnhill Clinic, PA

PATIENT FINANCIAL PROGRAM

[ ] ON-THE-JOB-INJURY: I was injured at work, and this claim is being submitted under my employer's Worker's Compensation Insurance. In the event that this claim should be rejected by that carrier, I understand that I am still liable for payment of all treatments and services. Patient Initials__________.

[ ] AUTO ACCIDENT: I was injured in an auto accident and this claim is being submitted through auto insurance. In the event this claim should be rejected by that carrier, I understand that I am liable for payment of all treatments and services. Patient Initials__________.

[ ] INSURANCE ASSIGNMENT: I have insurance and will make assignment to the doctor and/or clinic. Patient Initials__________.

DEDUCTIBLE: My deductible is $__________

[ ] I have met my deductible for the current year.

[ ] I have not met my deductible for the current year and will pay $__________on__________.

ESTIMATED PATIENT PORTION: In addition to my deductible, I understand that I am responsible for any amount not covered by my insurance policy(s). I will pay the estimated portion of my bill $_________ on a WEEKLY basis. Patient Initials__________.

PATIENT PORTION: The doctor and/or clinic shall receive the checks from my insurance carrier, and any amount due over and above the amount paid by my insurance and the amount paid by me shall be added to the ESTIMATED PATIENT PORTION and paid as stated above. Patient Initials__________.

REDUCTIONS AND REJECTIONS OF CLAIMS BY MY INSURANCE CARRIER DO NOT IN ANYWAY AFFECT MY OBLIGATION TO PAY THE BILL IN FULL.

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. SIGNED______________________DATE__________	I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED______________________ (INSURED OR AUTHORIZED PERSON)

[ ] **CASH AGREEMENT**: I will make payment in full for services rendered on my first visit and on a weekly basis thereafter. Patient Initials _____________ .

ALTERNATIVE METHODS OF PAYMENT: VISA MASTERCARD

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctors Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized lo be paid directly to the Doctors Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I understand that if I am accepted as a patient of the Barnhill Clinic, PA, I am authorizing them to proceed with treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request.

The Clinic, Doctors and Staff have implied no guarantee of cure.

I have read and agree to abide by the terms set above.

Robert D. Barnhill, B.A., D.C.

Barnhill Clinic of Chiropractic, P .A.

5270 N.W. 34th Street • **Gainesville,** FL 32605
(352) 377-2255

Patient's Signature X____ **Date**____________________

Guardian or Spouse's Signature Authorizing Care____________________________________ **Date**____________________