Carroll Chiropractic & Sports Injury Center

330 140 Village Rd., Unit 9A Westminster, MD 21157
(Phone) 410-876-8881   (Fax) 410-848-6343

Responsibility of Fees

I understand and agree that health and accident policies are an arrangement between an insurance company and myself. Furthermore, I understand that Carroll Chiropractic & Sports Injury Center 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 Carroll Chiropractic & Sports Injury Center will be credited to my account on receipt. **However, I clearly understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me is immediately due and payable.**

If my account is not paid within 90 days, I understand that I am responsible for legal fees, collection agency fees, and any other expenses incurred in collecting the balance due on my account.

I hereby instruct and direct my insurance company to pay by check made and mailed directly to Carroll Chiropractic & Sports Injury Center the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance company as payment toward the total charges for professional services rendered by this clinic.

I authorize Carroll Chiropractic & Sports Injury Center to release any information pertinent to my case to any insurance company, adjustor and/or attorney involved in this case, and hereby release this clinic of any consequence thereof.

Appointment Rescheduling and Other Office Calls

Most of our patients are aware that there have been many changes in the health care laws that were created in order to protect their privacy. Be that as it may, these laws (called HIPPA) generate a great deal of paperwork. These laws have also caused us (and every other health care provider) to be very careful about what and to whom we can speak to, even regarding the most general information.

This documentation is primarily to give this office permission to call you when you have missed your appointment and, hopefully, rescheduled that appointment for a more convenient time. It is also to give us permission to leave messages regarding other issues that may come up as to your care; i.e. referrals and other insurance related paperwork or problems. Please indicate below, for yourself and/or you minor child, as to how you would like us to communicate with you for the referenced issues.

☐ 1. May we call and leave a message on either an answering machine or family member, or anyone who may answer your home phone, regarding your missed appointment? (Check box if yes)

☐ No, you may not leave a message. You are only to speak with me.

☐ 2. If we can't reach you at home, may we call your place of employment and leave a message to reschedule your appointment? For example, leave a message with a receptionist or on your voice mail?

☐ No, you may not leave a message. You are only to speak with me.

☐ 3. May we leave a message on your answering machine or with a family member, or anyone who may answer your home phone about insurance paperwork issues? (Check box if yes.)

☐ No, you may not leave a message. You are only to speak with me.

☐ 4. If we can't reach you at home, may we call your place of employment to speak with you or leave a message on your voicemail or with a receptionist in order to clarify insurance paperwork issues?

☐ No, you may not leave a message. You are only to speak with me.

Signature of Subscriber or Beneficiary   Today's Date   Signature of Witness   Today's Date