Christopher Family Chiropractic
350 Alberta Drive, Suite #204
Amherst, NY
14226
Phone: (716)783-8778
Fax: (716) 783-8780

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I understand that I may be financially responsible for any charges incurred at the office, including co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize that my treatment plan may be subject to pre-authorization by the insurance company, and accept any responsibility for charges that may not be approved. The insurance company will review any/all documentation submitted by Dr. Christopher/Dr. Farrell for review for medical necessity and base their approval/denial upon this documentation. Insurance policy limitations are per individual insurance company policy plans, as are co-pays, co-insurance, deductibles, and referrals (patient is responsible for obtaining a referral).

I understand that this office agrees to notify me if a service is not covered and will notify me if the insurance company does not approve my care as soon as possible. If a treatment plan is approved this office will make me aware of the amount that the insurance will allow. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rending acute care, while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company.

This office will seek payment from you for any services your health insurance plan determines to be not medically necessary.

I have read and understand my obligations for payment for care in the event that my insurance denies a claim.

_____ _____
Patient's Printed Name Today's Date

_____ _____
Patient's Signature Parent/Guardian's Signature