



Milton Chiropractic
& Rehabilitation, Inc.



BAY STATE
PHYSICAL THERAPY

Acknowledgement of Office Policies

The following are Milton Chiropractic and Bay State Physical Therapy's policies governing appointment scheduling, payment terms, and information release. **Please read carefully and initial after each section before signing the bottom, and be sure to ask any questions you might have before signing the document.**

Appointment Scheduling. We at Milton Chiropractic and Bay State Physical Therapy are glad to accept insurance assignment on your behalf in handling payment for the care you receive. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. This means that if you miss several appointments without notifying our office (emergencies considered), you may be dismissed from care and your file may be closed. *We only treat those patients who want to get well.*

Consent for Treatment. I, the undersigned, give Milton Chiropractic and Bay State Physical Therapy my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, my condition may worsen on rare occasions, or injury may occur (ie. muscle spasm, rib injury, etc). I also understand that although rare, there are reported incidents of injuries such as stroke associated with common neck movements, including chiropractic adjustments, of the cervical spine. Present medical and scientific evidence does not establish a direct cause-and-effect relationship between cervical spine adjustments and the occurrence of injuries such as stroke. Risk of injury or complications from chiropractic treatments and physical therapy are substantially lower than that associated with many medical procedures or medications given for the same symptoms. I further understand that **no guarantee or promise** has been made to me concerning the results of treatment.

Assignment of Payment. I hereby **authorize** my insurance company and/or my attorney to pay direct to Milton Chiropractic & Rehabilitation and Bay State Physical Therapy any monies due on my account for professional services rendered.

Acknowledgement and Understanding. It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.)

Authorization to Release Information. I **authorize** this office to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office.

Patient Requests for Records. I **authorize** the release of all medical, hospital, or surgical records pertinent to my care, including but not limited to, exams, special tests, x-rays, or lab results to this office.

I certify that I have read and understand all appointment and office policies listed above.

Name (print) _____ Signature _____ Date _____

Witness (print) _____ Signature _____ Date _____