LOFT
CHIROPRACTIC

STEVEN E. LOFT, DC
3405 Orchard Park Road, Orchard Park, NY 14127 • (716) 675-0515
www.LoftChiropractic.com • LoftChiropractic@gmail.com

Patient Notification of Financial Responsibility

I understand that I may be financially responsible for any charges incurred at this office, including copayments, deductibles and charges denied or otherwise not covered by my insurance company.

I realize that my care may be subject to pre-authorization by my insurance company and I accept all responsibility for any treatments which are determined to be not medically necessary. I understand that my coverage does not cover routine maintenance, preventative, or wellness visits.

My initial office visit and examination is covered under my contract and will not be billed to me if continued treatment is determined to be medically necessary. Loft Chiropractic will submit all required documentation to the insurance company or their designee so that a review relative to determination of medical necessity can be made for subsequent treatment. I understand that Loft Chiropractic and myself will receive direct notification from the insurance company or their designee and will be advised as to whether additional treatment has been approved or denied and the number of visits that have been approved for a specific time period. Charges for services determined to be not medically necessary by the insurance company will be my responsibility to pay for.

Insurance policy limitations are per individual insurance policy plan as are copayments, co-insurance, deductibles, preauthorization, and/or referrals.

I have read and understand my obligations for payment and care in the absence of insurance coverage.

Signature _____

Print Name _____

Date _____

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Informed Consent to Chiropractic Treatment

Patient Name _____

Parent/Guardian (if applicable) _____

I understand and grant permissions and authority to the doctors and staff of Steven E. Loft, DC to provide chiropractic evaluation, treatment and other clinical office procedures for me (or my minor child above). I understand that results are not guaranteed. I understand that chiropractic treatment, like all forms of healthcare, while offering considerable benefit, may provide some level of risk. I have had the opportunity to discuss with office personnel regarding the aforementioned benefits, risks and alternatives. I agree to authorize any treatment which may be necessary, covering the entire course of care for which I seek. I realize that I will be included in the treatment and planning of my chiropractic care and compliance to my outlined course of treatment and other recommendations is commensurate with case success.

Signature _____ Date_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Name _____

Relationship to Patient _____

Signature _____

Date _____

*** YOU MAY RELEASE INFORMATION REGARDING MY MEDICAL INFORMATION AND/OR BILLING TO THE FOLLOWING PERSON:

Name _____

Relationship _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

Date _____ Initials _____ Reason _____