

**Chiropractic Center of Pelham Patient Agreement**

1. PLEASE INFORM FRONT OFFICE OF ALL INSURANCE AND APPOINTMENT CHANGES. OUR OFFICE IS NOT RESPONSIBLE FOR YOUR SCHEDULE OR YOUR CHANGES IN INSURANCE.
2. If patient is more than 20 minutes late for an appointment, appointment will be cancelled and the patient will be assessed a \$50 cancellation fee. While we are sensitive to the fact that emergencies sometimes do occur, no-shows decrease our ability to accommodate the scheduling needs of other patients.
3. A scheduled appointment must be cancelled AT LEAST 24 HOURS PRIOR TO APPOINTMENT TIME TO AVOID CANCELLATION FEE.
4. Signing this form authorizes Dr. Geoffrey A. FioRito to bill you for non-covered services and/or elective care, (see definitions below), in order to give you the best care possible. As a courtesy, Dr. FioRito will charge a global fee for all non-covered modalities performed during each treatment.

**Definitions:**

**Non-Covered Benefits** – Your plan may limit payment for certain devices/braces, supplies (such as vitamins) or services such as modalities/procedures (such as electric stimulation, ultra sound, hot/cold pack, massage etc.) per visit.

**Maintenance/Elective Care** – Maintenance/elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is deemed medically necessary by your health plan. You may also choose maintenance care once maximum benefit from treatment has been reached.

5. I certify that I am currently eligible for chiropractic healthcare benefits and have provided any necessary referrals. If it is deemed that I am not eligible for benefits at the time of service, I agree that I am liable for all charges.
6. I agree to pay in full for all services received within 30 days of receiving a bill from my provider.
7. If your account goes into collections, you agree that you will be responsible for the original balance, as well as any additional fees associated with the use of the collection agency.

(Initial) \_\_\_\_\_ I understand that I will pay all co-payments/co-insurance/deductibles directly to Dr. FioRito and the Chiropractic Center of Pelham

(Initial)\_\_\_\_\_ I hereby state that I am not eligible for No Fault/Worker’s Compensation

(Initial)\_\_\_\_\_ I have read the above and agree to treatment on the above terms

Thank you for your cooperation with our scheduling and payment policies. By having these policies in place, it allows us to extend the same great customer service to other patients that you would expect yourself. We hope your experience with us is an enjoyable one!

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_