ChiroStandard, PLLC
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Advance Notice and Agreement of Patient Financial Responsibility

Patient Name: **Date of Birth:** **ID:**

Your physician has recommended the following treatment plan to facilitate the best recovery from your current condition. The expected advantages of receiving the care and the disadvantages of not receiving the care have been discussed with you. You have indicated that any questions you may have had have been adequately discussed and you understand the answers.

You understand that each insurer has different opinions about what care is and is not medically necessary. This makes it difficult to determine the amount that will be reimbursed by an insurer and the amount for which the patient is responsible for payment until your insurer processes the claim and makes payment. You are aware that the resources required to render the care and, if required, to appeal these decisions may exceed the insurer's reimbursement.

Treatment Plan and Estimated Costs

Services to be Initialed	Service	Frequency	Duration Begin/End Date	Estimated Cost Prepaid / Paid at Time of Service

Options

Do you want the services initialed? Yes/No
Do you want your insurer(s) billed? Yes/No Medicare Advantage Plan Yes/No Other Insurer
Do you understand you are financially responsible for charges not paid by your insurer? Yes / No

	I want the services initialed. Bill my insurer. I accept financial responsibility for services not paid by my insurer.
	I want the services initialed. Do NOT bill my insurer. I accept full financial responsibility.
	I do not want the services I have not initialed.

Additional Information:

Patient's Signature: ______________________ Date: __________

Doctor's Signature: ______________________ Date: __________

A copy of this form is given to the patient at the time it is signed. Original maintained in patient's file.