FINANCIAL RESPONSIBILITY:

I understand that during the course of my treatment I will incur charges. I understand that payment is due at time of service. If I choose to use my insurance, I understand that any deductible and/or copay/coinsurance amounts will be required at the time the service is rendered. If for any reason the insurance company fails to pay, I understand that I am FULLY responsible for the amount not covered.

The staff at Sweetgrass Chiropractic will verify your Chiropractic benefits on your behalf, however, it is important to understand that the benefits verified are only a **QUOTE** and not a guarantee of payment. Ultimately it is the responsibility of the patient to know their benefits and accumulated amounts toward their yearly deductible before your scheduled appointment.

NOTICE OF PRIVACY PRACTICES:

I understand that I have the following rights and privileges:

- The right to review the PHI notice prior to signing
- The right to object the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, and healthcare operations.

I have read and understand all of the above:

Print Patient Name_____

Signature of Patient or Guardian:_____ Date____/____/_____