

## **FINANCIAL AGREEMENT**

We would like to take a moment to welcome you to our office and to assure that you will be receiving the very best care available for your condition. To familiarize you with the financial policies of our office, we would like to explain how your medical bills will be handled.

### **EXPLANATION OF INSURANCE COVERAGE**

Most insurance policies cover chiropractic/physical therapy care, but this office makes no representation that your insurance company does. Insurance policies can differ greatly in terms of deductible amounts and percentage of coverage for chiropractic/physical therapy care. Because of the variance from one insurance policy to another, we require that you, the patient, be responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance company(s) in a timely manner.

### **PRIMARY CARE PHYSICIAN REFERRAL(S)**

In the event that your insurance company requires a referral from your primary care physician, you agree that you are responsible for providing this office with the original referral within five (5) days of your first office visit. If the referral condition is not met, you agree to pay in full for all services provided to you within (30) days of receiving a bill from this office.

### **PAYMENT ARRANGEMENTS**

We do require that you pay 100% of your charges on a daily or weekly basis.

### **VOLUNTARY TERMINATION OF CARE**

If you suspend or terminate your care at any time, your portions of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged directly to you, and you ultimately, will be personally responsible for payment, regardless of your insurance coverage.

### **PHYSICAL THERAPY CANCELLATION POLICY**

As a part of our continued effort to provide you with the very best of service and accommodate all appointment requests, we have implemented a Cancellation Policy. As part of this policy, we are asking for your cooperation to reserve your time. As all services are provided by appointment only and this time is reserved for your exclusive use, we must request 24 hours notice to cancel or reschedule an appointment. There is a \$25 charge for canceling or rescheduling an appointment less than 24 hours in advance and/or for no-shows. We can confirm appointments in advance if you request and we also provide appointment cards, however this is done as a courtesy and the responsibility of canceling or rescheduling an appointment remains with you the patient. Your cooperation and understanding in this matter are greatly appreciated.

### **ASSIGNMENT OF BENEFITS**

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and other dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that will be bound by signature as though the undersigned had personally signed the particular claim.

Pay and hereby assign directly to Enfield Health & Wellness Center all benefits, if any, other wise payable to me for the services provided as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefit, when received by and paid to Kevin E. Sadowski, D.C. to be applied to my account, in accordance with the above said assignment. I also acknowledge that any insurance benefit paid directly to me for services rendered need to be signed over to Enfield Health & Wellness Center to be applied to my account.

I have read and understand the office's financial policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic and physical therapy procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the chiropractors and physical therapists who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other physical therapy procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of physical therapy and chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor and/or physical therapist to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor/therapist to exercise judgment during the course of the procedure which the doctor/therapist feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

**Enfield Health and Wellness Center, LLC**  
**143 Hazard Avenue**  
**Enfield, CT 06082**

**FORM: NOTICE OF PRIVACY PRACTICE SUMMARY**

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Enfield Health and Wellness Center, LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Enfield Health and Wellness Center, LLC will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Enfield Health and Wellness Center, LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Enfield Health and Wellness Center, LLC may disclose your information for; public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have the right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Susan Sadowski and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Enfield Health and Wellness Center, LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable request you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Susan Sadowski @ 860-763-2225.

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Patient Signature

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Date

**MEDICAL RELEASE**

I, \_\_\_\_\_ [Name of Individual], authorize \_\_\_\_\_ to release my Protected Health Information, as described below, to:

**ENFIELD HEALTH & WELLNESS CENTER**  
**143 Hazard Avenue**  
**Enfield, CT 06082**

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Complete Medical Record    | <input type="checkbox"/> Medical History, Evaluation Records | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Treatment or Tests         | <input type="checkbox"/> Hospital Records including Reports  | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Allergy Records            | <input type="checkbox"/> Laboratory Reports                  | <input type="checkbox"/> Px Data       |
| <input type="checkbox"/> Consultation Documentation | <input type="checkbox"/> Surgical Reports                    |  |
| <input type="checkbox"/> Other (Specify): _____     |  |  |

I also specifically authorize that any sensitive information regarding (CHECK ALL THAT APPLY):  HIV/AIDS,  Substance Abuse (alcoholism or drug abuse), or  Mental Health be released to the above referenced recipients.

It is my understanding that the information to be released will be used for the following purposes (CHECK ALL THAT APPLY):

- |  |  |
|--|--|
| <input type="checkbox"/> At the request of the individual (no purpose need be specified) | <input type="checkbox"/> Additional Medical Care       |
| <input type="checkbox"/> Insurance Eligibility/Benefits                                  | <input type="checkbox"/> Change of Provider            |
| <input type="checkbox"/> Other (Specify): _____  | <input type="checkbox"/> Legal Investigation or Action |

**INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATION:**

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke my Authorization or to receive a copy of my revocation, I am to contact Dr. Sadowski @ (860) 763-2225. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

**INDIVIDUAL'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**REPRESENTATIVE'S SIGNATURE (if applicable):** \_\_\_\_\_

**DESCRIPTION OF REPRESENTATIVE'S RELATIONSHIP:** \_\_\_\_\_