Intracoastal Chiropractic Clinic
14255 Beach Blvd.
Jacksonville, FL 32250

Assignment of Insurance Benefits and Direction to Pay

I hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and directly pay Dr. Robert DeVincentis for professional services rendered to me. This includes a direct assignment of my rights and benefits under any such policy of insurance.

This assignment of insurance benefits is provided so that Dr. Robert DeVincentis may attempt to collect any unpaid and over-due insurance benefits directly from the insurance carrier. I authorize any holder of insurance information about me to release such information to Dr. Robert DeVincentis needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize Dr. Robert DeVincentis to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf.

A copy of this agreement will be as valid as the original. I have read and I do understand this agreement thoroughly.

Patient/Guardian Signature____Date______________________________

Patients Who Have Insurance

I, the insured, understand and have been explained that Intracoastal Chiropractic Clinic does offer a discount off of the normal fees charged for services rendered if payment is made in full immediately after the services are rendered. By signing below, I choose not to take advantage of the discounted rates. Instead, I authorize Dr. Robert DeVincentis to bill my insurance company the normal fees for service.

I also realize that there is a possibility that my insurance company may not pay for certain services rendered by Intracoastal Chiropractic Clinic. Intracoastal Chiropractic Clinic does not promise or guarantee that services rendered to me will be paid by my insurance company. I agree to pay for all charges for services rendered to me if my insurance company denies payment.

Patient/Guardian Signature____Date______________________________

Appointment Cancellations

I understand that a minimum of **2 hours notice** is required to cancel or change a chiropractic or massage appointment. I also understand that a **$25.00 fee** will be charged to my account if the cancellation occurs without the 2 hour notice. I acknowledge that a message on the answering machine will **not** be accepted as a cancellation even if a two hour notice was given. I agree to remit payment if this occurs.

Patient/Guardian Signiture____Date______________________________

Financial Agreement

I understand and agree that if I fail to make any payments in a timely manner (including but not limited to the balances after insurance benefits have been received), after such default and upon referral to a collection agency, attorney, or small claims court by Dr. Robert DeVincentis, I will be responsible for all costs of collection of monies owed, including court costs, collection agencies, and attorney fees.

Patient/Guardian Signature____Date______________________________