# Standard Waiver of Liability

I assume financial responsibility for any and all charges incurred at this office. If insurance is being used towards my care, I understand that my treatment may be subject to pre-authorization and I accept any charges not covered by my insurance carrier. This can include copays, deductibles and any denied charges.

My insurance company will review any/all documentation submitted by Pueblo West Chiropractic Center for determination of medical necessity and coverages based upon their medical guidelines.

I agree to this office, Pueblo West Chiropractic Center, notifying me as soon as possible as to whether my chiropractic care is covered or limited by my insurance company. Upon waiting for approval from my insurance, I further understand that my initial visits may be denied and this may be beyond the office's ability to notify me prior to receiving said care.

Any payment due beyond thirty (30) days is permitted to being sent to a collection agency. Because of the services rendered to me, I agree to pay all collection costs associated with receiving the debt.

Note: Our office does not bill secondary insurance carriers.

## Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Dr. David Vik. I have read this document and acknowledge my obligations of providing payment for care in the absence of insurance coverage.

Signature (Patient, or Parent/Guardian of Patient)

Date

## Release of Medical Records:

I give my permission to Dr. Vik to request medical information from other medical facilities that may help him to accurately assess and treat my current condition.

Signature (Patient, or Parent/Guardian of Patient)

Date