

1. TREATMENT CONSENT & EXPECTATIONS

I _____ acknowledge Dr. Dalfino and the rest of the Connecticut Disc and Laser Therapy Centers staff has clearly explained the details of treatment. With my signature below I also give my consent to receive treatment and acknowledge that all of my concerns and questions have been expressed and competently and thoroughly answered by the doctor and/or staff. I understand the objectives of treatment being to relieve my pain and increase my mobility and my function. While it is expected that we will meet our objectives of improvement I also understand that nothing in healthcare is guaranteed. With a condition like mine, meeting these objectives may in fact not be possible and results, while unlikely, may be such that I may have no improvement at all or even feel worse. As such, I hold the doctor and/or staff completely harmless if expectations are not met. I am entering into treatment hopeful yet with the full understanding that my expectations may not be met and fully aware of the possible outcomes.

2. PAYMENT & FINANCING

Any and all treatment is expected to be payable at the time of service. If I choose to finance treatment, I understand that the financing is provided by a separate and distinct company unaffiliated with Connecticut Disc and Laser Therapy Centers. I have been informed and agree to the fact that my financing will be processed and paid in full on the day that I complete the financing paperwork regardless of when any scheduled appointments begin or end. Failure to be current with my payment may result in finance charges and/or treatment termination.

3. INSURANCE & MEDICARE

I understand that while Connecticut Disc and Laser Therapy Centers may or may not be in my insurance network it is possible I will not receive any insurance reimbursement for treatment, and I realize that this is purely a decision made by my insurance company. (This next statement is for Medicare recipients only... I have been informed by Connecticut Disc and Laser Therapy Centers staff that Medicare may not cover any of the services provided to me and therefore will not provide reimbursement. My signature below will serve as an appropriate ABN and NEMB forms, and I agree to be charged directly for uncovered services as agreed upon.) I understand that any insurance reimbursement is purely a decision of the carrier, and that I am ultimately responsible for any payment.

4. REFUNDS & PERSONAL ITEMS

All services paid for and received are non-refundable. Any services paid for but not completed are subject to a refund. Any and all supplementation, supports or DME are considered personal items and are considered non-returnable and non-refundable.

5. APPOINTMENTS & CANCELLATIONS

I understand and agree that any treatments, re-evaluations, consultations, meetings, exams, etc. scheduled with the doctor that are cancelled without a 24 hour notice, may be subjected to a \$125 fee. Any missed appointment without any prior notification (No Call / No Show) will automatically be charged a \$125.00 fee to the credit card on file. There are no exceptions to this policy. These appointment times are valuable and could have been made available to other patients who need care. Additionally, missed appointments without notice may cause unnecessary disruption to the clinic's schedule, including requiring staff to arrive earlier or stay later to accommodate other patients. In the event of a no call / no show, any and all of my future pre-scheduled appointments are subject to automatic cancellation, and it will be my responsibility to contact the office to reschedule. Following a no call / no show, future appointments will only be scheduled one at a time, at the discretion of the clinic. I agree to place a valid credit card on file and authorize the clinic to charge this card in the event of a no call / no show.

6. ACCOUNTS, COLLECTIONS & COMMUNICATION

I understand that in the event there is an issue arising regarding my account and financial responsibility to Connecticut Disc and Laser Therapy Centers, Dr. James J. Dalfino, At Best Chiropractic, LLC et. al – that in the event that my account becomes past due, the aforementioned will exhaust any and all measures to recover fees due the clinic. This may be in the form of collections, demand letters, or small claims. In the event that any or all of these measures are necessary, I agree that I will be held financially responsible for all fees incurred, whether I use outside financing or any office payment plan offered me. Chargebacks initiated by the patient in lieu of an arrangement and agreement made with the clinic will be subject to a \$250 fee. By my signature below, I give Dr. Dalfino and the office consent to contact me via email, fax, and phone.

Patient / Client Signature_____
Date