ARVADA SPORT and SPINE GROUP™

MEDICAL - PODIATRY - PHYSICAL THERAPY - CHIROPRACTIC - MASSAGE THERAPY

12189 W 64th Ave. Ste 102 Arvada, CO 303-424-9549 arvadasportandspine.com

Dear Valued Patient,

Over the past several years we have found insurance companies more and more difficult to work with. We commonly spend hours and hours on the phone and internet trying to advocate for you. While we will continue to advocate for you and make good faith attempts to help you use your benefits to your advantage, ultimately, the responsibility for your account lies with you. Since we don't choose your insurance for you, we cannot ever make any promise to you that they will pay. It is VERY IMPORTANT that you notify us of any insurance changes immediately. Please read the following paragraph carefully and acknowledge this in writing:

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that Arvada Sport and Spine Group will file my insurance as a courtesy where applicable. However, I clearly understand and agree I am ultimately responsible for all service fees related to my care should my insurance deny for reasons such as: an authorization, deductible, no coverage, non-covered services, insurance request for payment recoupment from Arvada Sport and Spine Group or any individual provider, or any other reasons. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I accept full responsibility for payment of all charges and authorize the treatment provided to me here at Arvada Sport and Spine Group.

I also understand that if I cancel a scheduled appointment within 24 hours / 1 business day of the set appointment time I will be subject to a $45 fee (per provider that you are scheduled with) that will not be billed to any insurance company and will be due immediately.

I have read and completely understand and agree to ALL of the above statements. I also understand that I may refuse to sign this document but doing so will disqualify me to be a patient at Arvada Sport and Spine Group.

Print Patient Name: _____

Patient/Parent Signature: _____

Date :_____