Richart Spinal & Sports Rehabilitation, Ltd
900 Waukegan Road
Glenview IL 60025
847-657-8686

Patient Name: _____ File# _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Richart Spinal and Sports Rehabilitation will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Richart Spinal and Sports Rehabilitation will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that any services not covered by my insurance carrier are my financial responsibility. I understand that if my insurance carrier deems a service experimental, investigational or unproven I am financially responsible for those services.

I understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I also understand that any unpaid amount if not paid within 60 days of the termination of care, may be sent to collections and all court, attorney and collection agency fees are my responsibility.

It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Patient's Signature: _____Date: _____

Guardian's Signature: _____ Date: _____

I acknowledge that I have received Richart Spinal and Sports Rehabilitation Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____