

Waiver by Insured of Health Care Policy Terms/ Contracts

To permit Advanced Healthcare to recover from
Collateral sources for services rendered:

I, the undersigned, being of sound mind and eighteen years of age or older, do hereby waive any applicable terms of my current primary and / or secondary health care insurance policies or any other requirement that may restrict my treating chiropractor/ medical doctor/ massage therapist (hereinafter referred to as “Advanced Healthcare”), from seeking to collect reimbursement for health care services rendered by Advanced Healthcare and for which reimbursement is due to me from collateral sources, to the extent permitted below. Such collateral sources may include, but are not limited to, automobile medical payments insurance, automobile liability insurance and third party recovery through court action or in settlement thereof.

I further acknowledge that Advanced Healthcare will not be limited to receiving the contractual rate for services provided in my current health care insurance policy and hereby request that Advanced Healthcare not deduct contractual deductions from my account but that they recover from other sources based upon their usual and customary rates. Notwithstanding the above, if I request coverage for these services under my health care insurance policy, Advanced Healthcare may collect only the difference between the amount paid and received from my health care coverage for services rendered and the amount of the collateral payment for such services.

I further acknowledge that any amounts due to Advanced Healthcare as permitted by this waiver shall be considered indebtedness for unpaid expenses to the creation of a lien for the purposes of Chapter 44 of the General Statutes.

This waiver has been executed simultaneously in counterparts, each of which shall be deemed original. At least one copy shall be left with the undersigned insured and another retained by Advanced Healthcare.

_____ *I have been informed and understand that I am not required to execute this waiver, and that my execution of this waiver is no way precondition of receiving services from Advanced Healthcare. I understand that at any point if I decide to have my primary health insurance cover my medical bills in full that I am responsible to pay my contractual portion of each of my visits to Advanced Healthcare so that my bill remains paid in full at all times. I understand that if I choose to do this I will submit my request in writing.*

(Signature)

(Date)

(Print Name)

(Witnessed By)

(Date)