

Financial Responsibility Notice

_____ (Initial) I understand my benefits have been verified as a courtesy and have been informed of my benefits, including my financial responsibilities. If I feel the information is incorrect, I will contact my insurance company directly and keep Boost Sports Performance, LLC updated regarding any changes in my insurance or policy/coverage. I understand this is not a guarantee of payment.

_____ (Initial) I hereby authorize payment directly to Boost Sports Performance, LLC any benefits payable to me, and I am responsible for charges not covered by my insurance company.

_____ (Initial) I hereby authorize Boost Sports Performance, LLC to obtain and release all or part of mine or my dependents records from / to any person or corporation which may be liable for all/part of the charges for these services, including but not limited to insurance companies, doctors, legal counsel, worker’s compensation carriers or employers.

_____ (Initial) All amounts due for services billed by Boost Sports Performance, LLC to a Worker’s Compensation payor was subsequently declared by my employer to be a non-eligible claim.

_____ (Initial) I understand my credit card will be stored by WorldPay, Inc., a secure credit card processor that partners with Boost Sports Performance, LLC to collect payments. Boost Sports Performance, LLC reserves the right to charge your credit card \$100/month for any unpaid patient balances ≤ \$500 and \$125/month for any balances > \$501 until the outstanding patient balance is met (after insurance carrier adjudicates the claim). You will receive a _____ phone message or _____ email BEFORE any charges are made to your credit card.

PRIMARY	SECONDARY
Available Visits: _____	Available Visits: _____
Copay: \$ _____	Copay: \$ _____
<i>***If deductible applies copay will not apply until deductible is met.***</i>	
Coinsurance: % _____	Coinsurance: % _____
<i>***Coinsurance % will be billed to the patient.***</i>	
Deductible: \$ _____	Deductible: \$ _____
<i>***Payment Due Toward Deductible-----Less Than \$1000: \$50/visit Greater Than \$1000: \$70/visit***</i>	
Out-of-Pocket: \$ _____	Out-of-Pocket: \$ _____
Self-pay: \$100 / Visit	
Total Due: \$ _____ /visit.	

I agree that The Boost Sports Performance, LLC will bill me for any balance due. I have read and agreed to the stated conditions.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____