

**David Frasure, D.C., P.A.**  
1342 Timberlane Road, Suite 102-B  
Tallahassee, FL 32312  
Phone: (850) 224-4268 Fax: (850) 727-0025

**Financial Responsibilities**

Dr. David Frasure no longer has a contract with any health insurance company, including Medicare/Medicaid. He also no longer accepts Workers' Compensation or Automobile Liability (personal injury) assignments.

Health Insurance is a contract between you, the patient, and the insurance company. Services provided by Dr. Frasure will be considered services provided by an out-of-network chiropractic provider. It is your responsibility to contact your health insurance company and determine the extent of your coverage for services provided by an out-of-network chiropractic provider. We will fill out and file any necessary insurance forms, if applicable, for reimbursement from your designated company, and these reimbursements will be mailed directly to you. Please note that, according to your health insurance plan coverage, your insurance provider will pay for services it determines to be "reasonable and necessary" and "usual and customary" (UCR). Your health insurance provider may reduce or deny payment for chiropractic services. You, as the patient, are personally and fully responsible for complete payment of services at the time they are rendered.

We endeavor to keep our rates as low as possible, while giving you the very best possible care. If you have any questions about your financial responsibilities, please ask a staff member or Dr. Frasure.

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**Authorization for Treatment**

I understand that if Dr. Frasure accepts me as a patient, I am authorizing him to proceed with any treatment that may be deemed necessary, after these treatments are discussed with me. I also understand that any risks regarding chiropractic treatment will be explained to me upon my request. Furthermore, I understand that chiropractic care, as with any medical treatment, is not an exact science, and there are no guarantees or assurances with any treatment received.

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**Patient's Acknowledgement and Acceptance of Financial Responsibility and Authorization for Treatment**

I have been notified in writing that I am fully responsible for payment of services at the time they are rendered, regardless of my insurance status, and I give my authorization for treatment as described above.

\_\_\_\_\_  
Patient's Name - PLEASE PRINT

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Legal Guardian or Patient's Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**Please complete the following ONLY if we are filing insurance for you:**

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Date