Patient's Name_______________________________________

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

Your HMO insurance company requires authorization after the first six or eight visits, depending on which insurance company you have. Our office does the best we can do to make sure that the visits necessary for your recovery are authorized; however, there are times when the insurance company does not authorize the number of visits we think are necessary. Also, your insurance company does not cover any therapy, such as ultra sound or stim therapy. There are some x-rays that the insurance does not cover and they do not include any supplements.

Please choose one option below and circle it:

Option 1. **Yes**, I want to receive these items and/or treatments and I agree to be personally and fully responsible for payment.

Option 2. **No**, I have decided not to receive these items or services if they are not authorized.

Signature:____ Date:_________________