Out of Network Waiver Form

Patient Name: _____

Physician Name: Chiropractic Sports Institute, Terry Weyman D.C.

Name of Insurance: _____

Your signature below signifies that you clearly understand that

Chiropractic Sports Institute is NOT a member of your health care plan. Because the doctor is NOT on your plan, the expenses for today's and all subsequent visits will be your responsibility. This means you will have to pay the doctor's charges in full at the end of each visit.

Our office will file a claim to your carrier as a courtesy. The time-of-service rates will be charged regardless of what insurance allows as an out of network provider.

Certain types of plans will not reimburse any money if the patient requests and seeks services from a physician that is NOT part of the plan or network.

Do not sign this form unless you positively understand the consequences of your visits, the charges you will have to pay, and the fact that you may not receive any of the money back from your insurance carrier.

I understand all of the above and still want to receive services from the non-participating physician.

Signature of Patient: _____ Date: _____