OUR OFFICE POLICY
REGARDING INSURANCE ASSIGNMENT

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified and the first explanation of benefits is received.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance, unless an HMO/PPO discounted contract is in effect with our office.

Office policy regarding insurance assignment is as follows:

1. Since by taking your insurance assignment we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.

2. If you discontinue care without the doctor's authorization, the balance of your account is due and payable in full immediately, even if your insurance has been filed. (If the insurance does pay, it will be refunded to you if you have a zero balance.)

3. Your insurance should pay within 30 days. We may ask for your assistance in calling for collection if beyond 60 days of being filed.

4. We will file your insurance as long as you are actively under Chiropractic care.

5. You are required to pay the percentage of your responsibility once we have received an explanation of benefits, unless other arrangements have been made.

6. You are required to sign an Authorization To Pay Physician form and any other assignment documents required by your insurance company on your first visit

7. Our office does NOT guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your insurance claim is denied, you are responsible for the full amount of your bill.

8. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

9. If you understand and agree with all of the above office policies, please sign your name below and we will accept insurance assignment once we have received an explanation of benefits which state what benefits will be paid.

_____   _____
PATIENT SIGNATURE   DATE

_____
WITNESS SIGNATURE