PLEASE READ CAREFULLY

Welcome to Chiropractic Healing Center! We are committed to providing you with the best chiropractic care possible, and look forward to a long and healthy relationship.

We will file your insurance claims automatically for you. It is imperative that you give us correct, updated and accurate insurance information. Your understanding of your specific insurance policy and of our payment policy will be of great benefit to our relationship. We will make every effort to answer any questions you might have. The following statements are areas that are most frequently misunderstood by the patent. Please review and initial.

1. **Not all services are a covered benefit**. Some insurance companies arbitrarily select certain services they will not cover. It is up to you, the patient, to know what these services are. We will do our very best to assist you in this area; however, this ultimately is your responsibility. _____ Initial

2. **It is your responsibility to know when a referral is needed**, and to obtain the referral before your appointment. If your primary care physician has any questions regarding the necessity, we will gladly answer them.

_____ Initial

3. **Some insurance policies have a higher co-payment due the specialist physician** than to the primary care physician. Please refer to your card or contract for that amount.

_____ Initial

4. **All co-payments, any deductible that has not been met, and services that are not covered by your contract, are due at the time of your visit**. If we do not participate with your insurance company, payment in full is expected at the time of service. We will file with your insurance company as a courtesy to you.

_____ Initial

If you do not have health insurance, financial arrangements must be made in advance with our billing receptionist. We accept cash, check, MasterCard or Visa. There is a $25.00 charge for any returned check. We reserve the right to require subsequent payments on such accounts in cash or by money order. Your signature below is your acknowledgement of this information. This serves as your authorization to release any necessary medical information to your insurance carrier, to process claims for services rendered. This also serves as your authorization of payment of all medical insurance benefits, which are payable under the terms of your insurance policy, to be paid directly to Chiropractic Healing Center, for services rendered.

Signature ______________________________________ Date _____________________