

PAYMENT FOR SERVICES

Insurance policies vary greatly in what services they will pay for. Some policies are more complete than others, and cover more services. Our office staff will try to contact your insurance company on your first visit, or soon after to find out what services are covered

by your contract. We do this in a sincere attempt to inform you of your expected health care costs.

WE CANNOT BE HELD RESPONSIBLE FOR WRONG INFORMATION PROVIDED TO US BY YOUR INSURANCE COMPANY!

1. We will be glad to prepare, and send your insurance claims for you. When we send in your claims we will "accept assignment". This means that your insurance company will pay their portion of your claim directly to our office.

YOU MAY STILL BE RESPONSIBLE FOR THE FOLLOWING:

- **DEDUCTIBLE**

An initial amount in medical expenses that you must pay each year before your insurance begins payment. You will be charged for each visit until your deductible is met .

- **CO-PAYMENT**

A percentage, or set dollar amount of all charges. Please pay your ESTIMATED co-payment at the time of service to help us reduce billing costs.

- **UNCOVERED SERVICES**

You are responsible for payment of any services not covered by your insurance company. If you have another insurance, it may cover services that your first insurance policy does not.

2. Insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

BENEFITS QUOTED BY EAST STADIUM CHIROPRACTIC OR YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF BENEFITS! RESPONSIBILITY FOR PAYMENT RESTS ULTIMATELY WITH YOU!

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, & Discover. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 1/2% per month. We will be glad to address any questions about the above information or any concerns regarding your insurance coverage, please don't hesitate to ask us.

By my signature below I acknowledge that I have read the above information, and agree that I am responsible for all costs incurred at East Stadium Chiropractic Wellness Center.

Patient Name (Printed) _____

Signature _____

(Under 18 years of age must be signature of parent or guardian)

Date _____