RIVER FALLS CHIROPRACTIC
Financial Disclaimer

Dear Patient,
Welcome to ***River Falls Chiropractic***! We are pleased that you have chosen our clinic to address your health care needs. We would like to take a few minutes to explain a little bit about what you can expect from your insurance company as well as what we in turn expect from you.

Your benefit under your insurance plan for chiropractic care may not cover all of your visits to our office. You are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. Most plans do not cover maintenance care, preventative care or care for chronic conditions. Please feel free to discuss any questions with our accounts department.

If your doctor feels that care will not be a covered expense based on the type of care you are receiving, it may be in your best interest to discuss one of the several financial plans we have available.

- If at anytime there is a <u>change in your insurance benefits</u> it is YOUR RESPONSIBILITY TO NOTIFY THE FRONT DESK. WE CAN NOT BE RESPONSIBLE FOR BACK BILLING IN THESE SITUATIONS.
- Please understand that any benefit quoted to you by this office is NOT A GARUNTEE that your insurance co. will make payment on your claims.
- YOUR PAYMENT IS DUE AT THE TIME OF YOUR VISIT. We welcome payments in advance by <u>cash</u>, <u>check</u>, <u>Visa</u>, <u>Mastercard</u>, and <u>debit cards</u>.
- If X-rays and/or a Spine Scan are determined to be needed by your doctor this would be an additional charge.

Also note: If you are filing your claims through AUTO INSURANCE or WORKMAN'S COMPENSATION, the insurance may not settle in your favor or your case may be denied, at which point you will be responsible to pay your balance.

By signing this statement, you acknowledge that you understand that the services you are receiving may not be covered by your health plan and in that situation you would be 100% responsible for all charges incurred.

____ ______________

Signature Date

It is our goal to provide the utmost in chiropractic care and to open the door to a new life of health and vitality for all of our patients!

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

Service/Product to be provided:_______________________________

Date of service:____

Cost of service:____

I____, acknowledge that I have been told in advance by my provider that the services/products listed above are not covered by my health plan. I agree to pay for these non-covered services.

Patient signature:________________________ Date:_________________