

Financial Responsibility

I understand that the billing of my insurance company on my behalf is a service provided by Ann Arbor Chiropractic Wellness Center and does not relieve me of my financial obligation. If co-payments and/or deductibles are requested from my insurance company or health plan, I agree to pay them. I agree to pay any co-payments and/or any other service charges on the date of service. For authorized covered services, I agree to pay my portion of the charges and understand that the exact amount of my obligation may not be known until after my insurance company or health plan has processed the claim. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. For services not covered by my insurance company or health plan, I agree to pay the full amount of the standard fee for services I have received. I am responsible for paying any charges outstanding if my account becomes past due and is referred to a collection agency or attorney and I agree to pay all collection expenses, attorney fees, and court costs. I understand that as a result of collection proceedings, the fact that I am/was a patient at Ann Arbor Chiropractic Wellness Center may become a matter of public record.

If I have a non-contracted insurance company (insurance pays you), I agree to pay in full for all services provided to me regardless of the amount reimbursed to me by my insurance company.

If no insurance is used at Ann Arbor Chiropractic Wellness Center, I agree to pay the charges in full and at the time of service.

Print Name

Date

Signature of Patient or Authorized Party

Description of Personal Representative's Authority