Van Skyhock Family Chiropractic

415 S. Elmwood Ave., Suite B, Traverse City, MI 49684
(231) 922-0219 Fax (231) 922-0224
www.TraverseCityChiro.com

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred in this office, including my insurance deductible, copayment and any services rejected by my insurance company (if applicable).

_____

(patient signature) (date)

THE COMPLEXITIES OF INSURANCE BILLING

We are required to bill "all" insurance companies a standard amount for "all" the services we render in this office. Please be aware that your insurance company will (99% of the time) reduce our billed amount to an amount they decide to approve. Each insurance company has its own approved amount and it is not possible for this office to know what the amount will be; therefore, we wait to see what is approved at the time payment is received.

You will not be "charged" the difference between what the insurance company does approve and our charges. What you will be charged for is the difference between the approved amount and what they paid. (Example: X-ray charge $100; approved amount from insurance $80; they paid $64 or 80%; we do not charge you the $36 difference, only the $16 co-pay between the approved and paid amounts.)

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this office, the professional and/or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____

(patient signature) (date)

RELEASE OF INFORMATION

I authorize this office to release any information pertinent to my case to your insurance company, adjuster and/or attorney involved in this case; and hereby release this clinic of any consequence thereof.

_____

(patient signature) (date)

I give permission for my name, picture or testimonial and/or my child's name, picture or testimonial (if applicable) to be used in this office.

_____

(patient/parent/guardian signature) (date)