

NAME \_\_\_\_\_ DATE \_\_\_\_\_

In compliance with federal and state consumer protection and informed consent laws, we present the following basic outline of usual and customary procedures and fees:

Detailed Initial Examination	65.00	Adjustment (1-2 areas)	46.00
Basic Re-examination	45.00	Adjustment (3-4 areas)	48.00
X-Ray (if necessary)	65.00-75.00	Adjustment (5-6 areas)	50.00
Therapy (if necessary)	20.00	Extremity Adjustment	25.00
Acupuncture	5.00		

**IF NO INSURANCE:** Payment is due when services are rendered. We do offer a same day pay reduced price for patients with no insurance. We gladly accept Master Card, Visa or Discover.

**IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS. WE WILL FILE ALL NECESSARY PAPERWORK FOR YOUR INSURANCE; HOWEVER YOUR INSURANCE IS YOUR RESPONSIBILITY.**

**INSURANCE:** Please pay 20% (or your coinsurance/copay) of your charges at your visit. Any procedures not covered by your insurance will have to be paid by you at the time of service. If you fail to keep your scheduled appointments or if you discontinue care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any insurance submitted.

**BLUE CROSS BLUE SHIELD:** Better Health Chiropractic is recognized as a participating provider of Blue Cross Blue Shield. You are responsible for any charges not covered by BCBS, copays, coinsurance, and deductibles. Any services BCBS declares "not medically necessary," you will be responsible for payment for these services.

**ASSIGNMENT OF RIGHT TO PAYMENT/LIEN AGAINST BENEFITS:** I hereby authorize Better Health Chiropractic to file my claim. I assign to them my right to receive any and all payments or recoveries for any insurance company, attorney, or third party for professional services rendered by Better Health Chiropractic. I convey a lien against any funds and authorize and direct any third party to withhold sums for any benefits, judgments, verdict, settlements, or recoveries, and to adequately protect and to make payment for these services directly to Better Health Chiropractic pursuant to this assignment and lien.

**ASSIGNMENT OF CAUSE OF ACTION:** In the event that any insurance company or third party obligated to make payment to me or Better Health Chiropractic for the charges made for services, refuses to make such payment upon demand, I hereby assign, transfer, and convey to Better Health Chiropractic any and all cause of action that might exist in my favor against any such company or person. I authorize Better Health Chiropractic to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses and resolve said claims as they see fit.

I hereby give permission to the doctor to release my information requested by my insurance company acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor.

I am financially accountable for non-covered services.

I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

**PAYMENT IS EXPECTED AND DUE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.**

**I HAVE READ AND AGREE TO THE ABOVE STATEMENTS:**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_