PARCHEM CHIROPRACTIC CENTER

PATIENT FINANCIAL RESPONSIBILITY & RELEASE FORM

Thank you for choosing **Parchem Chiropractic Center** as your health care provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- Before you begin treatment by **Parchem Chiropractic Center** we need you to understand the insurance (or other program) that will cover your chiropractic care. We also need you to understand your financial responsibility for paying any unpaid portion of your bill.
- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check and most major credit/debit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of **Parchem Chiropractic Center**. These charges include (but are not limited to):
  - -Interest charges of 5% monthly on remaining patient balances that are 30 days past due.
  - -Charge for returned checks.
  - -Charge for missed appointments without 24 hours advance notice
  - -Charge for copying and distribution of patient medical records.
  - -Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize **Parchem Chiropractic Center** and the staff associated with **Parchem Chiropractic Center** to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payers, attorneys, and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to **Parchem Chiropractic Center** and any associated health care entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize **Parchem Chiropractic Center** personnel to communication by phone, mail, answering machine message, and/or email according to the information I have provided in my patient registration information.
- **_____Consent to care for minor child:** I hereby authorize Dr. Parchem and whomever he may designate as his assistants to administer chiropractic care as he deems necessary to my child or relative.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____

Signature Date

Parchem Chiropractic Center
906 8th Avenue, Baraboo, Wisconsin 53913