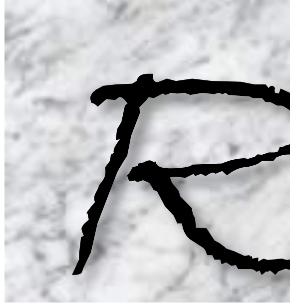

OCK FAMILY CHIROPRACTIC OF EUDORA

I Understand and agree that my health and accident insurance policies are an arrangement between my insurance company and myself- not between my insurance and this office.

I request Rock Family Chiropractic to complete any usual and customary reports and forms to assist in the collecting from my insurance company.

Further, I understand that my insurance may determine that a particular service is “not reasonable and necessary” or it is not covered under my contract standards and will deny payment for these services. **I agree to be personally and fully responsible for payment.**

I understand and agree that it is my **responsibility** to obtain all referrals that may be required by my insurance company.

Also, I have been advised, by the signing of this form, that should my account become delinquent, enforced collections is required that a service charge of $40.00 will be added to my account and interest will accrue.

I understand by signing this form that should a check be returned for any reason a $25.00 fee will be added to my account.

HEALTH INSURANCE: Yes ( ) No ( )

NAME OF COMPANY: ____

PATIENT SIGNATURE: ______________________________________DATE ____________

GUARDIAN SIGNATURE: ____________________________________DATE ____________

Are you a student? Yes ( ) No ( ) If yes, please list parent’s information below

Name ____

Address ____

City ________________________________State ___________Zip_________

Home Phone _______________________Work Phone_________________________