Chiropractic HEALTH & WELLNESS CENTER

Nathan L. Barkalow, D.C.
200 Oakridge Court
P.O. Box 667
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Phone: 920-787-4715
Fax: 920-787-1083

Financial Policy & Patient Responsibility

Patient Name (Print): _____ DOB: _____

Notice of Financial Responsibility

As a courtesy to you, we will bill your insurance carrier on your behalf. Please be aware that some or all the services provided to you may not be covered by your insurance company. Authorizations for medical treatment from your insurance company do not guarantee full payment for services. Actual benefits are determined by your insurance company after a claim is received. You are financially responsible for payments of outstanding deductibles and co-payments at the time of service.

As a patient, you are personally responsible for knowing and understanding your own insurance policy, including co-payment, deductible, eligibility, and coverage. Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.

Medicare

An Advance Beneficiary Notice stating that Medicare does not guarantee payment must be signed prior to receiving care. You agree to pay any balance after Medicare, or your supplemental insurance carrier, has responded to charges billed.

Workers Compensation / Auto Accident Claims

If a compensation or injury/accident claim is denied, you are responsible for payment of the charges. We will not accept third party billing if your case involves litigation. Our services are provided to you, not your attorney, and therefore you are ultimately responsible for the account. We will require you to make payments on the charges even if a third party will cover them.

Acceptance of Financial Responsibility

I hereby acknowledge my eligibility for health insurance benefits and coverage. In the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, I understand and agree to be fully financially responsible for payment of all costs incurred and I agree to pay all charges accordingly.

Patient (Guardian) Signature _____ Date _____

Name (Print)_____ Relationship to Patient _____