Wells Family Chiropractic, PLLC

Patient Name: _____ File: _____

Standard Waiver of Liability:

I understand I am financially responsible for any charges incurred at this office. This office is an out of network facility and any fees incurred will be due at time of service unless payment arrangements are made with the office staff. If I do have insurance and there is chiropractic coverage I will be reimbursed by my insurance directly.

I realize my coverage for care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation I submit that will be provided to me by Wells Family Chiropractic for medical necessity and final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-insurance, deductibles, referrals, etc.

I understand this office requires payment from me for any services provided and any payment due beyond 30 days is subject to late fees. I agree to pay all costs associated with collecting said debt.

Assignment of Benefits:

I have read this document and understand my obligations for payment for care in the absence of insurance coverage.

_____

Signature (Patient, or Parent/Guardian of Patient) Date

Release of Medical Records:

I give my permission for Dr. Chad Wells to request medical information from other medical facilities that may help the doctor to accurately assess and treat my current condition(s).

_____

Signature (Patient, or Parent/Guardian of Patient) Date