Corning Family Chiropractic, PC

FINANCIAL RESPONSIBILITY

I agree that I am responsible for payment of all charges for health care services provided to me. If applicable, I understand that an insurance card is necessary to validate my coverage for each visit. I understand that just because chiropractic care is a covered benefit of my insurance policy, that does not guarantee payment by them. I accept financial responsibility for all services provided to me by Corning Family Chiropractic, PC, and I understand that I will receive a bill for these services from Corning Family Chiropractic, PC.

ASSIGNMENT OF BENEFITS

I hereby assign to Corning Family Chiropractic, PC, any insurance or other third-party benefits available for health care services provided to me. I understand that Corning Family Chiropractic, PC, has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Corning Family Chiropractic, PC, I agree to forward to Corning Family Chiropractic, PC, all health insurance and other third-party payments I receive, for said services, immediately upon receipt.

MEDICARE BENEFITS

I certify that the information given to apply for Medicare benefits is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its intermediaries or carriers, any information needed for this or related Medicare claims. I request that authorized benefits be paid on my behalf.

WELLMARK PATIENT WAIVER

Wellmark Blue Cross/Blue Shield of Iowa's Physical Medicine Guidelines allow 2@ chiropractic visits per calendar year. I understand that I will be financially responsible for services beyond their limit.

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Patient's or Authorized Person's Signature Date

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Patient's or Authorized Person's Signature Date

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Patient's or Authorized Person's Signature Date

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Patient's or Authorized Person's Signature Date

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Patient's or Authorized Person's Signature Date