Shell Chiropractic & Wellness Center
a natural approach to a healthier you

Dr. June M Shell

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Statement of Patient Financial Responsibility

This office will contact your primary insurance carrier to verify your coverage and benefits. We will not however be held responsible for any financial miscalculation that derives as a result of misinformation conveyed by your insurance carrier. We will bill your insurance carrier/s on your behalf. As a patient, it is in your best interest to know and understand your responsibility for any co-payment, deductible and/or co-insurance prior to you visit and any scheduled procedure. You can gather such information by calling your insurance carrier and/or reading your insurance coverage package. Many insurance companies have additional stipulations that may affect your coverage. It is ultimately the patient's responsibility to know their coverage, benefits and payment responsibilities.

<u>You will be responsible for payment for the following:</u>

- Coinsurance or copay amounts
- Yearly deductible
- Non covered services
- Out of network charges (where applicable)
- Terminated coverage
- Denied Workers compensation claim
- No Insurance coverage
- No referral obtained from Primary Care Physician
- Failure to respond to coordination of benefits inquiry
- Failure to respond to insurance carrier correspondence
- If your insurance carrier denies any park of your claim
- Missed appointment/cancellation fee

If you find you are unable to attend your appointment, kindly notify the office 24 hours prior to your scheduled appointment. Failure to do so or failure to show up for the appointment will result in a $25 fee. Signing this document signifies that you understand.

If your insurance carrier requires a referral or authorization before you can be seen by a chiropractor, it is your responsibility to obtain such referral or authorization before being seen by June M. Shell, DC. If payment is denied for lack of referral/authorization, you understand that you will be responsible for payment in full.

Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you will be liable for full payment of the bill.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT UNDER THIS AGREEMENT.

_____ _____

Patient Name, (Printed) Witness:

_____ _____

Signature Date