

## Office Policy Explanation

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Case NO. \_\_\_\_\_

Payment is due upon receiving service. Our Office will be pleased to file your insurance for you. We will file your claim and assist you in every way we can. However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for receiving reimbursement for the services provided.

1. We will bill your insurance on a weekly basis, as long as you are receiving Chiropractic care in this office.
2. If you are not under one of our payment plans, you must pay for services at the time you receive them. This office accepts cash or check as payment.
3. **OUR OFFICE DOES NOT GUARANTEE THAT YOUR INSURANCE WILL PAY.** We will make every attempt, at the beginning of your healthcare, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, **YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF YOUR BILL.**
4. Our office will **NOT** enter into a dispute with your insurance company over your claim. **THIS IS YOUR RESPONSIBILITY AND OBLIGATION.**
5. All special arrangements regarding finances must be signed by the office manager, patient and/or guardian.
6. All X-RAYS and PATIENT RECORDS are to remain permanent records at Brett Chiropractic Center. Copies can be made at an additional charge.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_