BILLING AND INSURANCE (Doctor's Lien)

When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. We recommend that all patients verify their own insurance coverage as well.

I have read and understand that my insurance is an arrangement between my insurance company and myself. I request that Dr. Mandich's office prepare the customary forms so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor, that fees will be due and payable immediately.

I understand that I am personally responsible for any unmet insurance deductible and co-payments as well as for any charges for services not covered by my insurance contract, for any reason, whether the reason being my insurance benefits are exhausted or the insurance company deems my treatment or services not medically necessary. I will be responsible for paying those services rendered that are not paid by my insurance carrier.

I authorize use of my "Signature on File" on all of my insurance submissions and direct payment to this office (when applicable). If no insurance is filed on my behalf, I agree to pay for services as incurred. If my account should be turned over to a collection agency, I will be responsible for the balance of my account as well as any attorney and/or collection fees and court costs.

I also understand that if I am accepted as a patient by this chiropractic clinic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request.

Patient Name (print): _____

Responsible Party (print): _____

Patient/Responsible Party Signature: _____

Date: _____