COMMUNITY CHIROPRACTIC WELLNESS CENTER
MICHAEL A. DEFINO, DC
130 GREENFIELD AVENUE
SAN ANSELMO, CA. 94960

PERSONAL INJURY FINANCIAL POLICY
PLEASE READ PRIOR TO SERVICES RENDERED

ALL PATIENTS ARE TO PAY THE INITIAL EXAM FEE OF $250.00
PAYMENT IS EXPECTED AT THE TIME OF VISIT

All patients are required to pay at the time of their visit until Med Pay is verified. Chiropractic Visits are $60.00 per session. It is the patient's responsibility to contact their insurance company and verify MedPay as well as the amount of MedPay available. THE INSURANCE COMPANY CANNOT TELLL THIS OFFICE HOW MUCH MEDICAL PAY YOU HAVE. You will receive insurance billing forms to submit to your insurance carrier directly.

After you have verified "med-pay" benefits eligibility according to a valid insurance claim and have provided our office with the appropriate information to such, our office can provide billing services on your behalf. Reimbursement for services rendered will be directly remitted to our office. Charges will be applied for each visit; no discount will apply.

PLEASE NOTE:

A. If you decide to use your MedPay, a credit card number will be kept on file in this office for any outstanding bills that remain unpaid by the insurance company. You, the patient, are ultimately responsible for any and all bills incurred during your treatment.
B. This office WILL NOT accept cases for automobile or personal injury on a lien basis.
C. Any medical records requested by insurance carriers, patients, or attorneys will have $15.00 fee for copy service.
C. Payment for reports requested by your insurance carrier or attorney is the financial responsibility of the patient. A $75.00 per page fee will be charged.
D. Reports of any type will be issued to the specifics of services provided at this office.

We will do our best to provide you with what you need to settle your case.

Name of responsible party_____

Are you insured? Yes____ No_____ Carrier_____Claim#_____

Adjuster's Name_____Adjuster's Phone Number_____
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance carrier and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office the power of attorney to endorse checks made out to me, to be credited to my account. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature_____Date_____

Guardian / Spouse Signature Authorizing Care

_____Date_____Witness_____