



Dear Patient,

We have prepared this letter to help you better understand the complexities of health insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception-health insurance was not designed to pay for all chiropractic care. It is the patient's responsibility to know their contracts have time limits, exclusions, annual benefits maximums, and or various degrees of co-payments or co-insurance. Our office will look into your health insurance benefits and explain to you the basic information. We can NOT quote you an exact amount that would be your responsibility.

All levels of payment by insurance companies, include allowed fees, usual and customary (UCR), are governed by premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time and our constant dedication to supplying our patients with the highest quality chiropractic care. The treatment recommended by our office is never based on what your insurance company will pay; our treatment should not be governed by your insurance contract. With each insurance company we had to sign a contract to agree to participate with your insurance. This basically allows the insurance company to let us collect the allowed amount by their contract.

However, it should be understood, that the chiropractic contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful, please take the time to review your health insurance contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing and insurance.

Sincerely,

Your CHIROSport & Spine Team

I, the undersigned, understand that full payment is due at the time of service. Furthermore, I certify that I (or my dependent) have insurance coverage with _____, and all insurance benefits will be assigned directly to me, if any. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Signed:

Dated:

(relationship to patient) _____