FINANCIAL AGREEMENT

Your health is the sole responsibility of you the patient, or your guardian. We understand that finances are sometimes difficult and we do not want money to be the reason that interferes with your care. We are more than willing to work out an acceptable payment plan with you.

These obligations apply only to the services actually performed and in no way obligate the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within thirty (30) days of discontinuance of care.

Please select the type of payment you will use for your care:

☐ **NO INSURANCE** Cash, Check, Visa, MasterCard, American Express.

☐ **MEDICARE** Payment is due at time or service and A.K. Chiropractic Inc. will file the claims to Medicare for you.

☐ **PERSONAL INJURY** I will pay for all services at the time of service and will get reimbursed by the carrier myself or I will allow A.K. Chiropractic Inc. to file on my own PIP coverage. A.K. Chiropractic Inc. does not accept third party assignment. (Please let us know your choice)

☐ **INSURANCE** Please give the receptionist a copy of your insurance card and your drivers license.

Please complete this section only if you selected INSURANCE above

Primary Insured Name on the Policy ____
Relationship to Patient ____
Insurance Company ____
Group Number ____
Primary Insured Birth Date_____________ __________________________________
Primary Insured Social Security Number ____________________________________
Does the Patient have Secondary Insurance? ☐ Yes ☐ No (If Yes, Notify the Staff)

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ____ and assign directly to Dr. Ihoann Gonzalez all insurance benefits, if any, otherwise payable to me for services rendered in this office. I understand that I am financially responsible for all charges whether or not paid for by the insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Note: A.K. Chiropractic Inc. will refund any overpayment to the patient.

*Patient's Signature*_____________________________ *Date*___________________________

*Guardian*____________________________________ *Witness*_________________________