Sheldon Road Chiropractic
& Massage Therapy

Statement of Patient Financial Responsibility

Patient Name: ____

Sheldon Road Chiropractic & Massage Therapy appreciates the confidence you have shown in choosing us to provide for your health care needs. We aim to offer the best quality medical care to our patients. The services that you have elected to participate at our clinic do imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full for our services. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Thank you for your understanding and cooperation in this matter.

Co-Pay & Deductible Policy

(1). You as a patient are responsible for any co-payment/ co-insurance and/or deductible as determined by your contract with your insurance provider. We anticipate these payments at time of service unless other alternative arrangements have been determined. Some health insurance providers require the patient to pay a co-pay/ co-insurance for services rendered. This is a contract between you and your insurance provider. Payments of all co-pays/ deductible are expected at the time service is rendered for the patient, unless other payment arrangements have been set-up by the doctor.

(2). Many insurance companies have additional stipulations that may affect your coverage. It is ultimately the patient's responsibility to know their coverage and benefits. You as the patient are responsible for any and all amounts not covered by your provider. If your insurance provider denies any part of your claim, or if you elect to continue services past your coverage/ policy period, you will be responsible for your remaining balance.

I have read the above policy regarding my financial responsibility to Sheldon Road Chiropractic, for providing chiropractic services to me or the above named patient. I fully understand that I am ultimately responsible for any and all charges associated with my account. I certify that the information is, to the best knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Sheldon Road Chiropractic, the full and entire amount of bill incurred by me or the above named patient with the agreement that any amount remaining after such payment has been made by my insurance carrier becomes the patient's responsibility.

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Patient Name

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(Signature of patient or guardian if under the age of 18) (Date)