



Patient Name \_\_\_\_\_

Do you have health insurance that you would like us to bill for your visit? YES NO  
Auto Accident? YES NO Claim #/Ins. Company \_\_\_\_\_

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan
- If you are covered by a state or federal program with a mandated fee schedule
- If you are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization we may join. Patients who are un-insured or under-insured (limited benefits for chiropractic care) may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is \$49.00 per year and covers you and your dependents. Ask our staff for more information.

As part of our compliance plan, our office will be unable to extend any types of discounts other than those outlined above.

Any copays, deductibles, and/or fees are due at the time of service or promptly upon being billed. Thank you for your understanding and cooperation.

Alliance Chiropractic will gladly accept most health and accident insurance plans, and submit the necessary forms/claims required. By signing below, you authorize payment of medical benefits to Alliance Chiropractic and/or Dr. Jessica Leighton, as well as release of any information needed to process claims for services rendered. This includes medical information related to the claim. Alliance Chiropractic will not disclose any information to any other party without your explicit consent.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature (if patient is a minor): \_\_\_\_\_