Hendrickson Chiropractic & Health Center

508 N. Main Newton, KS.67114 ~316-283-6363~

Insurance & Financial Agreement

Patient Name:____ Date of birth:____________

Please check any and all insurance coverage that may be applicable in this case:

☐Major Medical ☐Worker's Compensation ☐Medicaid ☐Medicare ☐Auto Accident

☐Medical Savings Account & Flex Plans ☐Other

Name of insured:____

Date of birth of Insured:______________ Insured's Social Security #:_______-_____-________

Name of Insurance Co:______________________________ Insured's Employer:_______________

Are you covered by more than one insurance company? ☐Yes ☐No

Secondary Insurance Name:____

AUTHORIZATION AND RELEASE:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. **I understand that I am responsible for any non covered chiropractic services, regardless of insurance coverage, including any experimental treatments and that verification of benefits from my insurance company does not guarantee payment.** I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. **Any outstanding balance will be subject to an 18% interest rate if there is no payment made on the account for 2 months.**

HIPPA:

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning the privacy of your Patient Health Information. We encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_________________________________ Date:_______________

Guardian's Signature: _______________________________ Date:_______________