

Bass Lake Chiropractic
PATIENT LIABILITY STATEMENT

I understand that I am personally responsible for charges incurred for services rendered by the office of Bass Lake Chiropractic if any of the following apply:

1. My health plan does not cover 100% of the services rendered for any reason.
2. If I do not provide the office of Bass Lake Chiropractic with the correct insurance information.
3. I have chosen not to use my medical coverage at the time services are rendered.
4. I have a health plan that considers this office to be out-of-network or not otherwise a covered provider of service.
5. I have not obtained a referral, preauthorization, or other required authorization.
6. My benefit parameters limit or exclude coverage for therapy services.
7. My coverage changes during the course of therapy and/or no longer or does not cover and/or limits and/or excludes my therapy services.
8. I exceed my benefit limitations.
9. I understand and agree that in-network or out-of-network claims not paid by my insurer after 190 days become the responsibility of the guarantor/subscriber.
10. I understand and agree that all checks/payments sent to the insured by the insurer for services rendered will be signed over to Bass Lake Chiropractic when received.
11. I understand all bills for services rendered are also due upon receipt, including but not limited to bills for co-pays, deductible amounts and therapy. I also understand and agree to pay interest at a yearly rate of 30% on any remaining balance not paid within 30 days from the date of any bill.
12. If outstanding balances are submitted to collections, I understand and agree to pay any collection fees or costs, attorney's fees, and/or related costs and expenses incurred in pursuing any balance not paid within 30 days from the date of the bill.

I have read and understand the welcome letter summarizing policies and procedures set forth by Bass Lake Chiropractic and this Patient Liability Statement. By signing below, I hereby agree to the terms, conditions and provisions therein, and authorize services provided by Bass Lake Chiropractic.

Print Patient's Name _____

Signature of Responsible Person(s) _____

Date _____