Sussex Chiropractic and Wellness Center
www.sussexchiropractic.com ♦ N63 W23524 Silver Spring Drive, Suite 4 ♦ Phone: (262) 246 – 8811
Sussex, WI 53089

Patient Financial Responsibility

Patient Name: _____ Date of Birth: _____
Please Print (First, MI, Last)

I understand that I (or my guardian) am personally responsible for any charges which are rendered to my account. I am aware that there are several payment options available to me at the time of service, to include:

- Cash
- Check
- Credit card (Mastercard, Visa)
- Insurance (group or individual; Medicare/Medicaid, Work Comp, Personal Injury)

_____ **(Please Initial)** I understand that my insurance policy is an agreement between me and the insurance company. Since there are many variations in the HMO's and PPO's of today, I acknowledge the importance of understanding the health and accident benefits listed in my policy. As such, I will consult my insurance card(s)/policy and contact the benefits department for verification of my chiropractic coverage and the dollar amount and/or percent of my visit(s) that will be covered;

_____ **(Please Initial)** I understand that Sussex Chiropractic will initially call my insurance company, *as a courtesy*, to verify insurance coverage. To the best of their ability, they will attempt to ESTIMATE what my co-insurance/co-pay will be at each visit, but I understand that this is not a guarantee of what the insurance company will pay;

_____ (Please initial) I understand that certain services, such as re-evaluations and chiropractic adjustments may not be covered by my insurance plan. If my insurance company denies payment of chiropractic services and if any balance to my account is not paid by the insurance company for any reason, including but not limited to medical necessity, it is my responsibility to make payment toward those services. Furthermore, if I elect to continue care, I agree to accept full monetary responsibility for services rendered. I am also aware that any overpayment made by my insurance company on my account will be refunded.

_____ **(Please Initial)** I understand that it is the policy of Sussex Chiropractic to collect any deductible, co-insurances or co-pay from me at EACH visit, unless other arrangements are made;

_____ **(Please Initial)** I understand that Dr. Loftus and the staff work diligently to make sure every appointment is accounted for, according to each person's schedule of care. Although emergencies may arise, I understand re-scheduling time with the doctor is often difficult to do, and may affect my treatment schedule. As such, I am aware that a $25.00 'Missed Appointment Fee' may be charged to me for any appointment missed without 24 hour notice;

_____ **(Please Initial)** I understand if care is terminated by me (the patient), payment for services is due IN FULL immediately; interest may be assessed to the unpaid balance after 30 days;

By signing below, I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage and that interest may be charged on overdue accounts at the annual rate of 18%. I also understand that if I suspend or terminate care as determined by my treating doctor, any fees for services will be immediately due and payable.

_____ _____
Signature of Patient / Parent or Guardian *Date*