WELCOME TO OUR OFFICE

In compliance with Federal and State consumer protection and informed consent laws, we present the following basic outline of usual and customary procedures and fees:

Examinations	$50.00-150.00	X-ray examinations	$40.00-300.00
Adjustments	$40.00-60.00	Missed Appointments	$50.00
Physical Therapy	$10.00-80.00	Massage Therapy	$15.00-90.00

CASH PATIENTS: Payment is due when services are rendered unless prior financial arrangements have been made with Gerstenkorn Family Chiropractic, P.C. Missed appointments will be charged to my account.

INSURANCE PATIENTS: Payment is due at the time services are rendered. I understand that I am personally responsible for my portion of my bill and any other /amount that my insurance carrier does not cover. If I fail to keep my scheduled appointments or if I discontinue care for any reason other than discharge by the doctor, my bill is due and payable in full immediately. Missed appointments will be charged to my account and will be my responsibility.

ASSIGNMENT OF RIGHT TO PAYMENT /LIEN AGAINST BENEFITS: I hereby authorize Gerstenkorn Family Chiropractic, P.C. to file my claims. I assign to them my right to receive any and all payment or recoveries from my insurance company, attorney or third party for professional services rendered at this office. I convey a lien against any finds and authorize and direct any third party to withhold sums from any benefits, judgments, verdict or settlements and to adequately protect and to make payment for these services directly to Gerstenkorn Family Chiropractic, P.C., pursuant to this assignment and lien.

ASSIGNMENT OF CAUSE OF ACTION: In the event that any insurance company or other third party obligated to make payment to myself or to Gerstenkorn Family Chiropractic, P.C. for the charges made for services, refuses to make such payment upon demand, I hereby assign, transfer and convey to Gerstenkorn Family Chiropractic, P.C. any and all cause of action that might exist is my favor against any such company or person. I authorize Gerstenkorn Family Chiropractic, P.C. to prosecute said action to collect fees due for care rendered and legal expenses and to resolve said claims as they see fit.

In the event that I, the patient or legal guardian, refuse to make payment upon demand for the charges made for services by Gerstenkorn Family Chiropractic, P.C., I agree to the following. I authorize Gerstenkorn Family Chiropractic, P.C. any and all cause of action and to prosecute said action to collect fees due for care rendered all finance charges accrued on a monthly basis and all reasonable/customary legal expenses incurred in this collection process against myself, the patient or legal guardian.

LIMITED RELEASE OF MEDICAL INFORMATION: I authorize Gerstenkorn Family Chiropractic, P.C. to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

If patient is a minor, print child's name _____and sign as a parent/legal guardian below.

Patient/Parent/Legal guardian Signature_____ Date_____