**475 Chippewa Mall Drive Suite 155**

**Chippewa Falls, WI 54729**

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 **Financial Agreement and Legal Assignment of Benefits**

**Financial Agreement**

**It is our policy to collect co-pays, co-insurance or deductible at the time of service. All fees must be paid in full before your next visit.** Our office gladly accepts credit cards, HSA/FSA, cash and personal checks. If you are financially unable to make full payment at the time of service, we can set up a payment plan. You should request this option as early as possible, preferably on the first visit. You will be billed for all unpaid charges. If you do not understand your statement balance, please call the office for an explanation of charges on the statement.

Please note that your **primary health insurance is not a guarantee of payment** for treatment rendered, **and you, the patient, are responsible to verify your own benefits** as well. Your exact benefit amount is determined after we bill your insurance carrier and receive an explanation of benefits from them. *You will receive the same explanation from your insurance company describing your exact dollar amount owed.*

**Assignment of Benefits**

1. I authorize the release of any information deemed appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred at this office.

2. I authorize and assign the direct payment to you of any sum I now or hereafter owe to your office by my attorney out of the proceeds of any settlement of my case, and by insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.

3. I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill, for treatment.

4. In the event any insurance company under contractual agreement refuses to make payment upon demand by you, I hereby assign transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit. I further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

 Dated: \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_ Dated: \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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 Patient Name Witness Name

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 Patient Signature Witness Signature

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 Parent / Guardian’s Signature