FINANCIAL POLICY

Many of our patients plan to file for insurance benefits for the care they receive in our office. If you have insurance, please indicate the insurance company name below. We will do our best to obtain accurate information regarding your eligibility and chiropractic benefits. Should your insurance company misquote benefits, you are responsible for any additional amounts owed due to their error. Likewise, if a misquote results in your financial responsibility being less than anticipated, we will either issue you a refund or apply any credit balance to future treatment.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that Melman Chiropractic Group, P.C. will prepare any necessary reports and forms to assist me in making collection from my insurance company.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my treatment, any fees for services rendered to me will be immediately due and payable.

INSURANCE COMPANY:_____

I authorize my insurance carrier to issue payment directly to Melman Chiropractic Group, P.C. with the understanding that all monies will be credited to my account upon receipt. I authorize Melman Chiropractic Group, P.C. to release information regarding my treatment if required by my insurance company in order to obtain payment. If my arrangement with my insurance company requires that payment be made to me, I hereby direct my insurance company to mail payment to

Melman Chiropractic Group, P.C.
667 Boylston Street, 4th Floor
Boston, MA 02116

PATIENT'S
SIGNATURE_____Date_____
Insurance ID / Group #:_____ / _____

GUARDIAN'S
SIGNATURE _____Date_____