Patient Financial Agreements

I understand that health and accident insurance policies are an agreement between and insurance carrier and myself. I understand that any future insurance problems, situations, etc. that arise with my insurance carrier will have to be addressed by myself.

I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment of all services and products.

I understand that I am responsible for payment of any laboratory services that are prescribed for me by the doctor at the time the kit is received. I further understand that if I return a prepaid laboratory test kit for a refund of moneys, there will be a $50.00 administrative processing fee, and that the return of funds may take up to 30 days from the time of the test kit return. In addition, I understand that there will be no return of funds I choose to return prepaid laboratory test kits after 90 days.

If I am prescribed nutritional supplementation and elect to purchase these products it is my understanding that I cannot return for refund any refrigerated items at any time or any other product after 90 days. A 15% restocking fee may be charged for returned products.

I hereby authorize the doctor to treat my condition(s). The doctor will not be held responsible for any pre-existing medically diagnosed condition (by another doctor), or any previous medical diagnosis.

X_____ _____

Patient / Parent's Signature Date

X _____

Printed Name

** Attention Blue Cross Blue Shield Insurance Patients:

The doctors of this clinic are providers with Blue Cross Blue Shield of MN for chiropractic services only. Specialized laboratory test procedures, acupuncture, laser and nutritional consultations are considered a non-covered service through the office, and I fully understand that I am responsible for the payment of these services in full at the time services are received. I understand completely that these services will not be submitted to Blue Cross Blue Shield or any other of their affiliate companies. I understand that there may be treatment and fee schedule limitations that I will have to abide by for chiropractic services. If I have an insurance deductible with Blue Cross Blue Shield for covered services, I understand and agree to pay in full for all services until I have met the deductible amount.

The applied kinesiology testing procedure portion of the initial chiropractic exam is a non-covered service. I understand and agree to personally pay that portion in full.

The insurance company does not pay for all re-examinations under chiropractic. I will be responsible for them.

Nutritional supplements, pillows, orthotics or other miscellaneous supplies are non-covered items.

I have read and full understand the above information regarding laboratory tests, insurance and payments and I am clear on the policy of this clinic. The above policy applies to all future testing and treatment as well.

X_____ _____

Patient / Parent's Signature Date

X_____

Printed Name