



INSURANCE WAIVER – ANTHEM BCBS / KAISER / MEDICARE

Your insurance carrier will not pay for some/all the procedures you may receive at your new patient appointment and on subsequent visits. The fact that your insurance company may not pay for a particular service does not mean that you should not receive it. New patient visits are \$125. By signing this waiver, you agree to pay any fees not covered by your insurance company, not to exceed \$125. *(There may be exceptions with Select Kaiser policies.)*

Your insurance only pays for very limited chiropractic procedures. Therefore, we will only bill for manipulations (adjustments). Any other procedures (electric stimulation, heat or ice, ultrasound, laser therapy, etc.) received are to be paid by the patient.

SERVICE(S) BILLED DIRECTLY TO YOUR INSURANCE CANNOT BE SELF-SUBMITTED.

If you elect to receive two services on the same visit, there will be an additional fee for the second service *(this does not apply to massage or acupuncture when your policy has those benefits)*. **Please note: Your insurance may not cover two services on the same day, nor does it cover K-Laser, Shockwave or Decompression.**

I agree that I have been informed of the Insurance Waiver Policy notice. Any questions that I may have about this statement have been answered and I fully understand and agree to comply with the policies as outlined above.

Patient/Legal Guardian Signature

Patient Printed Name

Today's Date

ASSIGNMENT OF BENEFITS

I authorize and direct that payment be made directly to: **Hatch Chiropractic & Wellness, 19767 E. Pikes Peak Avenue, Parker, CO 80138** for any and all insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under my insurance or pre-paid healthcare plan.

Patient/Legal Guardian Signature

Today's Date

AUTHORIZATION AND CONSENT

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid healthcare plan or Medicare. ***If at any time you wish to revoke this consent it must be done in writing.***

Patient/Legal Guardian Signature

Today's Date

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance companies or pre-paid healthcare plan will cover or pay for all my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Patient/Legal Guardian Signature

Today's Date

