

HEALTH INSURANCE PATIENTS

PLEASE READ: YOUR INSURANCE MIGHT NOT REIMBURSE THIS CLINIC FOR SERVICES RENDERED. YOUR PORTION OF THE BILL COULD BE LARGER THAN YOU EXPECTED....READ ON

Often there is a discrepancy between perceived and actual coverage offered on health insurance plans. Washington Chiropractic attempts to maintain contractual agreements with most major insurance companies. Actual and up-to-date credentialing can often vary between providers and insurance carriers. Information listed on health insurance company's web pages is often out-dated and non-specific. Washington Chiropractic makes a great attempt to be current with all insurance authorization, compliance, and mandates. Washington Chiropractic has contracted with Chapin's Medical Billing to assist in the billing process. They can be reached directly by dialing 206-243-2911.

Washington Chiropractic accepts health insurance for third party payment as a service to its patients. As well, this clinic assists with the often daunting task of authorization and prior authorization when required. Please understand this process can be complicated, time consuming, and have associated cost of doing business to this clinic. Specifically, time of service discounts only apply to same date of service payments and prior to any insurance direct billing and or contact. Time of Service discounts are available through this clinic and could be more affordable in some cases. Please inquire within.

Insurance coverage will change throughout the life of your policy so keeping abreast of the new updates and remaining in contact with your insurance plan representative is beneficial to your personal understanding of your own insurance coverage.

Please note Washington Chiropractic requires all patients to acknowledge their financial responsibility for provided care. Often, ancillary procedures are required by your insurance company as part of proper record keeping and patient management. All balances related to care provided by this clinic are ultimately the patients responsibility, regardless of authorization, prior-authorization, network status, covered or non-covered services, denials, and or request. You are acknowledging your financial responsibility for provided care by signing this form. **In short: You are responsible for all remaining balances not covered by your insurance. It is often best to call your insurance on your own behalf.**

Patient Name (Print): _____

Patient Signature: _____

Parent/Legal Guardian Signature: _____

Date: _____

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