Assignment of Benefits/Financial Obligation:

Patient Name/Guarantor:_____
DOB_____

MacFarland Chiropractic appreciates the confidence you have shown in choosing us to provide for your health care needs. As a courtesy, we will verify your insurance coverage and bill your insurance carrier on our behalf. If the insurance carrier does not make full payment for any reason, you are ultimately responsible for your bill.

You are responsible for payment of any deductible or co-payment/co-insurance as determined by your contract with your insurance carrier. We expect co-pays to be paid at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurance carrier. If your insurance carrier denies any part of your insurance claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to MacFarland Chiropractic, LLC, for providing services to me or the patient named above. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurance to pay any benefits to MacFarland Chiropractic, LLC, the full or entire amount of the bill incurred by myself or the above-named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature:_____ Date:_____