

SUMMIT CHIROPRACTIC & REHABILITATION, PC
Drs. Ivo Waerlop, DC and Dr. John Asthalter, DC
PO Box 300, Dillon, Co 80435
(970) 513-9234

PAYMENT POLICY

If we are not contracted with your insurance company, we will gladly provide you with information necessary for you to file the claim with your company. **Payment will be expected the time of the visit.**

For those patient's who insurance we participate, we will file your claim as a courtesy for you. If you have a co-payment for your visit, payment is expected at the time of the visit. If you insurance does not pay the claim in a timely manner, you will need to call them to pursue payment. Ultimately, the account is your responsibility, since your policy is a contract between you and the company itself.

WE WOULD APPRECIATE YOUR COURTESY IN REGARDS TO CONCELLATIONS. IF YOU CANNOT KEEP AN APPOINTMENT PLEASE CALL AND INFORM US, SO THAT ANOTHER PATIENT MAY BE SCHEDULED. IF YOU FAIL TO NOTIFY US OF A CANCELLATION THERE WILL A CHARGE OF \$50.00.

AUTHORIZATION

I certify that I have read and understand the information contained within this document, to the best of my knowledge. The above questions have been accurately answered and I understand that providing incorrect information can be dangerous to my health. I authorize Summit Chiropractic and Rehabilitation and staff to release any information including the diagnosis and the records of any treatment or examination rendered to me and/or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor, insurance benefits payable to me. If, for any reason, my insurance company pays directly to me any funds for services, I understand that monies is to be returned to Summit Chiropractic and Rehabilitation for any unpaid balances on my account. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of Patient (or parent of a minor)

Date _____