

**INSURANCE AGREEMENT AND INFORMATION: If you have insurance and would like Watson Chiropractic, P.C. to bill your insurance company please read below, sign this agreement. We will also need a copy of your insurance card, please have this ready when you submit this form.**

If your insurance company covers Chiropractic care, Watson Chiropractic, P.C. can process the paperwork and bill your insurance company. *It is important for you to understand insurance contracts are between you and your insurance company, and you are responsible for any amount not paid by your insurance company.* In accepting your insurance this office is extending a credit to you. Those patients who pay in-full for treatment, at time services are rendered, receive a 20% discount on those services. Those patients who make a partial payment, co-payment, or ask us to send them a billing statement after their insurance has processed their charges will not receive a 20% discount on services.

Terms:

1. Watson Chiropractic, P.C. reserves the right to choose which insurance companies we will bill. If this office chooses not to bill your insurance, payment is expected at time service rendered unless other arrangements are made with this office.
2. If we do not accept your insurance and/or you pay in full at time of service, we can mail claims to your insurance company so you can be reimbursed directly by your insurance. Or we can give you a receipt that you can submit to your insurance company for reimbursement.
3. This office will verify your insurance coverage by the end of the next working day. This office will make every attempt to obtain accurate verification of your policy coverage (i.e., unmet deductible amounts, co-payments or percentage of coverage, and services covered by your plan). However, *we cannot guarantee that the information your insurance company gave us is accurate or that your claims will be paid as stated.*
4. If we are unable to obtain verification of your policy coverage before services are rendered, this office may request the initial payment in full.
5. This office does not guarantee your insurance will pay for care. If your insurance company denies payment, you are responsible for 100% of billed charges.
6. You are responsible for any charges your insurance applies to your annual deductible. If you have any unmet deductible, you maybe required to pay at the time of service, until your deductible is met.
7. You are responsible for any non-covered charges and all amounts not paid by your insurance for services or supplies provided to you at this office. Payment is expected in full, at time of service, for all supplements, supplies and durable medical equipment, as these items are typically not covered by insurance.
8. If you have a credit balance on your account, after this office receives all insurance payments for all services or supplies provided to date, you will receive a refund. Or you may use the credit balance for future services or supplies.
9. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment, in full, regardless of any insurance company's arbitrary determination of usual and customary rates.
10. Your insurance company should pay within 30-90 days. If your insurance company has not paid within 90 days, you may be required to pay the balance due at that time.
11. If you choose to discontinue or dismiss yourself from care without the doctor's authorization, the balance of your account maybe due and payable, in full, at the time of discontinuance, even if your insurance claims have been submitted.
12. If, at any time, this office becomes uncertain that your insurance will pay for services rendered, this office has the right to terminate this agreement.
13. This office is not obligated to enter into a dispute with your insurance company regarding any claims for reimbursement.
14. For those patients involved in a personal, work or automobile injury cases who have retained an attorney, a lien form will need to be signed by you and your attorney in order for credit to be extended to you.
15. If/when your insurance company refuses to pay for treatment, your bill will be due and payable at the close of your injury case, or within 12 months of the date you have been released from care for that case, unless other arrangements are made with this office.
16. Health information collected about your case will be kept confidential in our office. If a claim is submitted to a payer, your health information may be shared with the payer. The health information your payer receives is considered confidential by the payer.
17. I authorize the release of any medical or other information necessary to process claims. I also request payment of government or medical benefits to either to myself or to Gonzzo Watson, D.C. dba Watson Chiropractic, P.C. on any bills/claims for services furnished to me.
18. I permit a copy of this authorization to be used in place of the original and I have read, understand, and agree to the terms stated above.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature of Patient or Person acting on patient's behalf

\_\_\_\_\_  
Today's Date