

Financial Responsibility

My care at Rosenthal Chiropractic, P.A. will be taken care of in the following way (Please check the appropriate box below):

PERSONAL: I am personally responsible for any charges incurred at Rosenthal Chiropractic, P.A. (cash, check, mastercard, visa).

My parent or legal guardian _____ has agreed to pay for all of my charges incurred at Rosenthal Chiropractic, P.A. Please send bills directly to:

Parent or Guardian's Name: _____

Address: _____

Phone: (Home) _____ (Cell) _____

HEALTH INSURANCE: Please bill my health insurance company for my care at Rosenthal Chiropractic, P.A. I understand that I am personally responsible for any charges not covered by my insurance for whatever reason. This includes, but is not limited to, deductibles, co-insurance, co-pays, ineligible expenses, uncovered services, visits without a referral, non-certified/non-preauthorization visits, etc. I agree to pay my balance at the time of each visit.

I am being given advanced notice of possible non coverage of services due to my insurance company deeming care as not medically necessary. I understand that if services are denied, I am financially responsible.

AUTO ACCIDENT INSURANCE **WORKER'S COMPENSATION INSURANCE**

Have you completed a PIP (Personal Injury Protection) application yet? Yes No

Name of insurance adjuster: _____

Phone number of insurance adjuster: _____

Claim number: _____

Auto insurance deductible amount: _____

Do you have a lawyer working on your case? No Yes

If yes, lawyer's name: _____

OTHER INSURANCE: _____

I have read the above, have completed it to the best of my knowledge, and agree to comply with its terms and conditions.

Patient's Name: _____

Patient's Signature: _____ Date Signed: _____

Parent/legal guardian's name (if minor) _____

Parent/legal guardian's signature _____ Date Signed: _____

ROSENTHAL CHIROPRACTIC, P.A. 507 South Maryland Avenue
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