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, denied visits, non-certified/preauthorized 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 or uncovered. I understand that if services are denied, I am financially responsible.

(_____) **WORKER'S COMPENSATION INSURANCE**
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
Wilmington, Delaware 19804
302-999-0633, 302-999-9826 (Fax)