

**Patient Responsibility Form**

Thank you for choosing Heppe Chiropractic for your chiropractic needs. We are honored by this choice and committed to providing you with the highest quality of care. We ask that you read and sign this form to acknowledge your understanding of our patient policies.

**Insurance Coverage:**

* **It is your responsibility** to be aware of your insurance coverage, policy provisions, exclusions, and limitations as well as authorization requirements. This information is furnished by your insurance carrier.
* We attempt to verify that your coverage is valid at the time of your visit. We will use the information provided by your insurance company; however, this information is limited and occasionally inaccurate. Ultimately, the financial responsibility for payment for services rendered is yours.

**Insurance Changes**

* If you have **ANY** changes in your insurance coverage—even if there is only a small change—you must notify us. Failure to do so, may result in denial of your claim which would then be your responsibility.

**Co-payments, Co-insurance, and Deductibles**

* **Patients are responsible for the payment of copays, coinsurance deductibles, and all other treatments not covered by your insurance coverage.**
* Payment is due at the time of service and for your convenience, we accept cash, credit cards, and checks (you are responsible for returned check fees) at our office.

**Insurance Request**

* You are responsible for responding to any request from the insurance company for further information. Not doing so, will result in a claim denial, making you responsible for payment.

**Collection Accounts:**

* In the case your account is referred to a collection agency, you are responsible to pay all fees if applicable.

**Missed Appointments – the below will be enforced at office discretion based on the reason for cancellation/missed appointment and previous history.**

* You will incur a no-show fee of $50.00 if you do not show up for scheduled appointments.
* All appointments require 24 hour cancellation notice, or you will be charged $50.00
* Arriving late to an appointment may require rescheduling, which could incur a late cancellation fee of $50.00.

 **Refusal of Service: Heppe Chiropractic reserves the right to refuse service based solely on our judgement and may do so at any time. This could be for chronic missed appointments, refusal to pay, misconduct with staff, or any other reason we deem appropriate. We do not owe an explanation for our decision to refuse service.**

**I have read, understand, and agreement to provisions of this Patient Responsibility Form:**

**Name of Person Responsibility for this account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**