Private Health Insurance
FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS

The purpose of this document is to clarify the financial details regarding your care. Please read the agreement below and initial each.

- If you have Private Health Insurance coverage, as your primary, for **"OUT-OF-NETWORK CHIROPRACTIC"** care we will submit your claims for services on your behalf to your insurance company. _____
- Our fees are based on the area averages for the specific services rendered. The severity of your condition coupled with the amount of time needed for you to reach your health goals will determine the amount and types of services that you will receive. _____
- Because Pro Neuro Health is an "OUT-OF-NETWORK CHIROPRACTIC" provider, we are not contracted or affiliated with any insurance carrier. Your claims are submitted to your insurance company as a courtesy and benefit to you. You are liable for ALL unpaid services by your insurance carrier and all unpaid balances on your account. **We do not reduce or write off any remaining balances**. _____
- Pro Neuro Health is contracted with "Physicians Reimbursement Services". They are the insurance biller and liaison between us and the insurance company. They are also the liaison between you and us for all billing and claim processing. You will be receiving statements from them, should you have any question or inquiry regarding the statement or a pending claim you will need to contact them directly. They will have all of the pertinent data needed to answer your questions. _____
- At each visit we will collect payment for the services rendered based upon your "OUT-OF-NETWORK CHIROPRACTIC" benefits. _____
- The information received at the "verification of benefits" is in NO WAY a guarantee of payment by your insurance carrier. They reserve the right to deny payment. _____
- You have employed your insurance company to work for you. We will not become involved in any disputes between you and your insurance company regarding the policy as purchased. At all times you are financially responsible for all services. _____
- All product purchases are to be paid in full, at the time of purchase. _____
- Pro Neuro Health reserves the right to modify the financial agreement, discontinue the accepting of insurance or the manner of collection of payment for services rendered without notice. _____

We ask that you give a full **business day's notice** for schedule changes or cancellations. This allows us time to contact patients that are waiting for appointment availability.

A MINIMUM fee of $25 will be charged and collected if proper notice is not given for a schedule change or cancellation. The fee will not be billed to your insurance company you will be responsible for the payment.

In cases of a "no show" or a "last minute cancellation" the dollar amount charged and collected will be that of the usual charge for your visit. Of course, individual circumstances will be taken into consideration.

If you might be, or are running late for an appointment, please contact the office as soon as possible so that we can do our best to accommodate you. This then allows us to make adjustments in the schedule—if possible. If we do not receive a call and you arrive late for the appointment there is a possibility that the visit will need to be rescheduled in order to provide you and the patients following with a complete and effective visit.

These policies are in place so that we are able to provide each of you with the very best care possible. Affording each and every patient with the quality time they deserve and need is imperative. Providing prompt, quality service to each of our patients is just one of the things that sets this clinic apart.

Patient Agreement: I authorize assignment of any and all benefit, payment, claim or judgment to Pro Neuro Health. I understand that I am directly and fully responsible to Pro Neuro Health for all financial obligations incurred and that this agreement is made solely for the protection of Pro Neuro Health. I have read this agreement, been given the opportunity to ask questions and understand the agreement. (A copy of this signed agreement is provided to the signer upon request.)

_____	_____	_____
Responsible Party (Signature)	Patient Name (Printed)	Date