PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Fletcher Chiropractic as your chiropractic provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian if minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures not covered or approved by their insurance plan. Copays are due at the time of service. Coinsurance, and deductibles and non-covered items are due 30 days from receipt of billing.

*PRINT NAME*_____

*SIGN NAME*_____

*Parent or Guardian if under 18 years of age*_____

*DATE*_____