

## Financial Responsibility Statement

Are you going to use your insurance? Yes  No

Policy # \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Are you the primary member? Yes  No

If not, primary member's name, phone # and birthdate: \_\_\_\_\_

Has your deductible been met for this calendar year? Yes  No  Not Sure

If you are not financially responsible for this account, who is?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### Statement to Cure

Chiropractic and the professionals of this office make no claim to cure any condition, but only to adjust subluxations (misalignments of the spine) thus restoring better nerve supply for restoration of health.

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Bryn Gillow and Life is Good Chiropractic, LLC will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Dr. Bryn Gillow and Life is Good Chiropractic, LLC will be credited to my account upon receipt. If covered by insurance, I clearly understand that I am responsible for my co-payments and deductible.

However, if I have no insurance coverage, I clearly understand and agree that all services rendered are directly charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_