Belleville Chiropractic and Wellness Center
PH: (608) 424 1840

1100 Bellwest Blvd
Belleville, WI 53508
Fax: (608) 424 1815

INSURANCE POLICIES/CASH POLICIES

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. I authorize this Chiropractic clinic release any medical information and complete any usual and customary reports and forms at no charge to assist in collection from my insurance company. If mine is a regular health insurance case, I agree to pay a percentage of service as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my scheduled care determined by my treating doctor, any fees for professional services will be immediately due and payable. **If at the time of services rendered, I have no insurance coverage I understand that I will need to pay for services rendered by my choice of cash, credit card, debit card, or check. All payments are due at the time services are rendered.**

Health Insurance **Yes / No** **Cash** **Yes / No**

Insurance Company: _____ Policy/Member #:_____

Insurance Carrier DOB: _____/_____/_____

Secondary Insurance Company: _____ Policy/Member #:_____

Insurance Carrier DOB: _____/_____/_____

***SIGNATURE*_____ *DATE*_____**

MEDICARE PATIENTS ONLY

I request that payments of authorized Medicare benefits be made either to me or on behalf of Belleville Chiropractic and Wellness Center, for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determines these benefits payable for related services. This authorization is in effect until I choose to revoke it. If you are a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.