J. STUART GARNER, D.C.

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(856) 582-1717

FINANCIAL RESPONSIBILITIES

I, _____, have furnished Garner Chiropractic with my health insurance information. I am requesting that Garner Chiropractic submit claims for service rendered on my behalf. However, I am fully aware of the following:

[ ] I understand and accept financial responsibility for any deductible, co-insurance/co-pay or non-covered services by my health insurance-all of which is payable at the time of my visit;

[ ] I understand that if I fail to pay my financial responsibility within 30 days of billing there will be a late fee assesed to my account then and every 30 days thereafter;

[ ] I understand that any delinquent account (any "patient balance" six (6) months past due) will be given to a collection agency and possibly reported on my credit report;

[ ] I understand that Garner Chiropractic will verify my benefits as a courteousy however, the understanding of my individual policy is my responsibility, If I have any questions, I will call my health plans Member Services Department;

[ ] I understand that if a claim has not been paid within 90 days of submission I will be notified by Garner Chiropractic and take an active part in the recovery of the claim;

[ ] I understand that if my insurance company fails to pay a claim within six (6) months, financial responsibility will become mine;

[ ] I understand that under special circumstances, financial arrangements may be made.

My signature acknowledges that I have read and understand the above.

_____ _____
(signature) (date)

_____ _____
(office staff signature) (date)