NYC Corrective Chiropractic Care

280 Madison Ave. Suite 1211
New York, NY 10016

Patient Financial Statement/ Assignment of Benefits

I hereby authorize assignment of my rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any unpaid balance by my insurance company, shall I be billed. In the event I receive checks with explanation of benefits directly from my insurance company, I will forward these checks along with attached statements in a timely manner.

I hereby authorize outstanding bills to be charged to my:

Master Card/ Visa/ Amex
Name as it appears on card_____
Card number_____exp._____
Billing address_____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and the patient.

- Our policy requires payments in full for all services rendered at time of visit, unless other arrangements have been made. If an account is not paid within 90 days of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process my insurance claims.

- I fully understand the above information and guarantee this form was completed correctly to the best of my knowledge. I know it is my responsibility to inform this office of any changes to the information that I have provided above.

Patient Signature: _____ Date: _____
Witness: _____ Date: _____