OLSEN
CHIROPRACTIC CENTER

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FEE SHEET

PLEASE READ THE FOLLOWING AND MARK THE APPROPRIATE BOX.

We are required to process certain paperwork for particular types of billing cases. Please inducate which type of patient you are so that we can be thorough in handling your case.

( ) I believe I am a **CASH** patient. Cash patients are responsible for all of their charges and must pay for them at the time of service unless other specific arrangements have been made.

( ) I believe I am an **INSURANCE** patient. Insurance patients are responsible for all their charges. This office may or may not choose to bill your insurance company and accept assignment for payment towards your account. We must have a copy of your insurance card. After your insurance coverage has been verified, you will need to pay your deductible, co-payments and any charges not paid by your insurance company.

( ) I believe I am a **MEDICARE** patient. We must have a copy of your insurance card. You will be responsible for your annual deductible if you do not have a secondary policy.

( ) I believe I am a **WORK INJURY** patient. If a valid claim is not established, the patient is responsible for all charges.

( ) I believe I am a **PERSONAL INJURY** patient. Personal injury patients have usually been in an auto accident or have had a slip and fall type injury where someone else is liable for their medical charges. Extensive paperwork and documentation is needed; sometime lawyers are involved. If a valid claim is not established, the patient is responsible for all charges.

I understand that there is a fifteen ($50) dollar late fee and/or 18% interest that will be assessed on all dates of service that are 30 or more days past due and that I will continue to incur a fifteen ($50) dollar late fee every 30 days until the balance is paid in full. I agree to pay attorney fees and costs if legal action is required to collect for services.
I acknowledge that my medical records will be retained for seven (7) years from date of service. Any medical records older than seven (7) years may be destroyed.

I hereby give permission to the doctor to administer treatment and perform such procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

Patient's Name _____ Date _____