



475 W. Governor Road, #3
Hershey, PA 17033

PATIENT NAME _____

PATIENT PAYMENT POLICY

WellCare Chiropractic's fee schedule is based on usual and customary fees for the type of services provided.

Generally, your insurance policy will cover some portion of the services provided. ***Please note: There is no guarantee of payment.*** Should your insurance carrier deny payment, the total uncovered balance will be transferred to personal pay and will be your responsibility. ***You are responsible for any deductible, co-pays, co-insurance or ineligible charges.***

Monthly statements will be sent to your home advising you of the status of your account. Payment for your portion of the services, as outlined on the monthly statement under the "Due From Patient" column must be paid within 30 days of receipt of the statement, or there will be a 5% interest fee applied.

Patient will be paying:

- A co-pay of \$ _____ per visit
- A deductible of \$ _____; and/or
- A co-insurance of _____ % per visit.

I attest that my insurance coverage and personal financial responsibilities regarding my treatment have been fully explained to me.

Patient (or Guardian)

Date

WellCare Chiropractic Representative

Date

WellCare Chiropractic appreciates your cooperation and welcomes the opportunity to serve you.