BELLEVUE CHIROPRACTIC CENTRE

Bill Walsh, DC
Bridget Walsh, DC
Richard MacDonald, DC

"Improving Function, Improving Life"

Clinic Policies

We believe that a clear definition of our clinic policies will allow us both to concentrate on the most important issue – your health. We will be happy to answer any questions you may have regarding our policies, your account, or insurance coverage.

Patient Payment Policy
Payment is expected at the time of service. Most insurance policies cover chiropractic care. We will be happy to file your primary and secondary insurance claims as a service to you. We cannot take responsibility for what your health insurance will or will not cover. Your co-pays and deductible payment are expected at the time of service. However, the patient's health needs are paramount, and, upon your request, our staff will arrange for payment plans if need be. Properly documented Worker's Compensation and auto accident claims are not required to be paid at the time of service.

Appointments
In order to better serve our patients, we ask that you call if you are unable to make your appointment or if you will be late.

Emergencies or After Hour Calls
In case of an emergency, you may contact the office for a special appointment any time during regular office hours. If you, a friend, or family member requires after hours or weekend assistance, you may call the clinic for special assistance.

Who is responsible for your bill?
___ Self ___Spouse ___Parent ___Insurance ___Worker's Comp ___Auto Insurance ___Medicare ___Medicaid

We welcome you to ask the doctors or staff about questions about your account or any aspect of your care. Getting you well is our primary concern.

I have read the Bellevue Chiropractic Centre Policies and will honor them.

_____ _____
Patient Signature Date

Insurance Information

Insurance Company Name _____ Phone Number _____
ID# _____ Group# _____
Name of Insured _____ Relationship ____self _____spouse ____parent
Insured's DOB _____ Insured's SS# _____
Insured's Phone # _____ Insured's Employer _____

Assignment and Release
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Bellevue Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctors to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____
Responsible Party Signature Date