Your signature below forms a binding agreement between Precision Chiropractic Health, P.C. and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We will bill your medical insurance as a service to you. As the Responsible Party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Present all current insurance cards prior to the first office visit.
- Present new insurance cards if insurance should change at any time.
- Pay any required copay at the time of the visit.
- Pay any additional amount owed within 30 days of receiving a statement from our office.

By signing below, you agree to accept full financial responsibility as a patient who is receiving chiropractic services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) ____

Patient Signature ____Date ___________

Responsible Party Name (Please Print) _______________________________________

Responsible Party Signature _______________________________ Date___________

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Name of Policy Holder____

Insurance Company___________________________ ID#:________________________

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to this office for any service furnished by Jennifer Carrasco, D.C., Alan Furman, D.C., Ross Ginsberg, D.C. or Frank R. Sherman, D.C. I authorize any release of medical information to the insurance company regarding these charges.

Patient Name (Please Print) ____

Patient Signature ____Date ___________
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