Healing Hands Chiropractic Care
Sherri Prestwich, D.C.
624 Wilson Avenue, Tullahoma, TN (931) 455-6040

Concerning Insurance Coverage for D.N.F.T. Chiropractic

When insurance coverage information for services rendered in this office is obtained from your insurance carrier, other than by an Explanation of Benefits (EOB) or a Remittance Advice document, the following legal disclaimer is given by that carrier:

> "Benefits are based on the information given today. Final determination will be made when claims are received, due to possible contract changes or policy cancellation."

If this office obtains your insurance coverage by telephone conversation from your insurance representative, this legal disclaimer is read to us before any benefits you may have are stated. Basically, the final determination of coverage for services provided by this office will be determined when your insurance carrier receives and processes the claims for those services, regardless of what we are told over the phone.

Having provided this information, please complete the following information concerning payment for chiropractic services rendered by this office.

Patient Release for Insurance Benefits to be Paid Directly to Healing Hands Chiropractic Care

Who is responsible for payment of this account? _____
Relationship to Patient_____

Name of Policy Holder _____

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

My Financial Responsibility

I certify the above information is correct. I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles, co-payments, or non-covered services as may be required by my insurance plan.

X _____ _____
Signature of patient or person acting on patient's behalf Date

My Authorization

I authorize the release of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X _____ _____
Signature of patient or person acting on patient's behalf Date