Back Neck & Disc Center of Gresham

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATLEY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSION SERVICES RENDERED.

FURTHERMORE, I UNDERSTAND THAT BDN **CENTER OF GRESHAM** WILL PREPARE NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO ***HINOJOSA FAMILY CHIROPRACTIC*** WILL BE CREDITED TO MY ACCOUNT ON RECEIPT.

HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY REPONSIBLE FOR PAYMENT.

I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH INSURANCE STATUS OF THE ABOVE INFORMATION.

_____ _____

(Signature) (Date)

_____

(Printed Name)