MILLER CHIROPRACTIC WELLNESS CENTER
4446 MAIN ST., SUITE 100
SNYDER, NY 14226
716-204-0743
FAX: 716-204-0747
E-MAIL: drmiller@miller-chiro.com

STATEMENT OF ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges which may not be approved. The insurance company will review any/all documentation submitted by Dr. Miller for review for medical necessity and base their approval/denial upon this documentation. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand that this office agrees to notify me if a service is not covered and will notify me if my care is not approved by the insurance company as soon as possible. If a treatment plan is approved, this office will make me aware of the number of office visits allowed. Initial visits may be denied and this may be beyond the office s ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. These charges will be the patient s responsibility if denied by the insurance company.

This office may seek payment from you for any services your health insurance plan determines to be not medically necessary.

In the event that I am responsible to pay privately for services received, I understand that the rates listed below are subject to change without notice at any time. The fees listed are special rates for payments received on the same date that the service is rendered. If I am unable to pay on the same date I receive service, I understand that I will be billed at the usual and customary fee schedule at a higher rate.

Initial Office Visit	$60.00
Re-Exam	$45.00
Office Visit	$38.00

I have read and understand my obligations for payment for care in the absence of insurance coverage. In the event that I need to make private pay arrangements, I will notify the office in advance to arrange a financial plan.

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PRINT PATIENT S NAME SIGNATURE(Patient, parent or guardian)

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DATE