



Renée J. Gordon, D.C.

Patient Financial Responsibility

This office will provide insurance billing services for you, if you so desire, as a courtesy. **Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding balances or charges incurred in this office.**

Patients who do not have health insurance:

Since we will not have to incur administrative fees to bill and follow up with insurance companies, we pass the savings on to you. We offer EVERYONE our **Time Of Service** rates when their accounts are **paid in full on each visit**. A written copy of our fee schedule is available upon request.

Initials

Patients with insurance have two options: (Please initial next to your choice)

1. You can pay our regular fee schedule and we will bill insurance for you. This notifies the insurance company that your deductible should be reduced by what you pay on each visit. If and when the deductible is met, you will be responsible for any co-payment and/or co-insurance.

(Please Note: This Is The ONLY option for Medicare Patients)

Initials

OR

2. You can pay our **Time Of Service** fees, which are significantly less than our regular fees. However YOU will then be responsible for submitting all services you have paid for to your insurance for reimbursement. We will NOT be billing on your behalf.

Initials

We will strive to work out feasible payment options for anyone in need of care. Unless other prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent. Please note that cancellations require 24 hours advanced notice, any cancellations made on the day of your scheduled appointment may result in a \$35.00 charge for which you will be responsible. Patients arriving more than 15 minutes late may be rescheduled out of courtesy to other patients, and exceptions are at the discretion of the doctor.

I authorize payment of insurance benefits directly to Renée Gordon, DC. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below I indicate that I have read, understand and agree with the terms on this page.

Signature

Date

CA Signature

Date