

FRIED CHIROPRACTIC CLINICS

Moline Office 1715 5th Avenue Moline, IL 61265 309-762-1050 Sherrard Office P.O. Box 527 Sherrard, IL 61281 309-593-2966

FINANCIAL POLICY

Insurance: All professional services rendered are the responsibility of the patient/guardian regardless of the type of insurance you have (i.e. Automobile accident/personal injury, worker's compensation; private/group insurance, Medicare or Medicaid). We will file your insurance claims as a courtesy to you. We will do our best within our legal limits to support your covered services; however your health insurance is an agreement between you and your insurance carrier and not between your insurance company and this office. Payment from your insurance company is not guaranteed. You are responsible for any unpaid charges.

I understand that third party insurance companies do not cover or pay for services that they determine to be not "medically necessary" or when services do not meet their predetermined care guidelines and therefore may deny payment for the services provided to me by Dr. Richard Fried

I grant Dr. Fried and his staff permission to release my records to my insurance company in order to show "medical necessity" for the services that I received. I agree to personally pay for services provided to me by Dr. Richard Fried that are determined to be not "medically necessary" or do not meet predetermined guidelines by an insurance company

Assignment and Release: I certify that I, and/or my dependent(s) have insurance
coverage with and assign directly to Dr. Kienard G
Bried/Bried Chiropractic Clinics all insurance benefits, if any, otherwise payable to me
for anyting rendered T understand that I am financially responsible for all charges
whether or not noid by insurance. I authorize the use of my signature on all insurance
submissions. The Brief may use my health care information and may disclose such
information to the above named insurance company(les) and their agents for the purpose
of obtaining payment for services and determining insurance benefits of the benefits
powerful for related services. This consent will end when my current treatment plan is
completed or one year from the date from the date signed below. It is understood that at
services free inhal are charned directly to the trainen/guardian. Who is personally
responsible for payment to this office. In the event it should be necessary, all collection
fees, court costs and attorney fees will also be the patient s/guardian s responsibility.
Your signature below represents your agreement with these policies.
Patient Name V Date V
Patient Name ¥ Date ¥
Signature