

LEVIN & CHELLEN CHIROPRACTIC

SHARON R. LEVIN, DC
Doctor of Chiropractic

NELS H. CHELLEN, DC
Doctor of Chiropractic

BLUECROSS INSURANCE USERS NOTICE

(please initial after each item)

- 1) You are responsible for paying for any "non-covered" services or products. _____
- 2) In the event that your insurance company denies liability for your care, payment for services rendered becomes your responsibility. _____
- 3) In the event that your insurance company misquotes your benefits and later denies liability for your care, payment for services rendered becomes your responsibility. _____
- 4) I agree to participate in disputes, if any should occur, by communicating with this office immediately and by communicating with Blue Cross regarding my claims if asked to do so by this office. _____
- 5) You are responsible for notifying Levin and Chellen Chiropractic whenever there is a change in your benefits or policy. _____
- 6) If you have a copay, this amount is due at the time of service. You will receive an Explanation of Benefits document from BCBS detailing what your remaining responsibility (deductible or coinsurance) for further payment is for the visits listed. _____
- 7) When this office receives the Explanation of Benefits notifying us of your deductible or co-insurance responsibility, we will contact you by phone or email about your balance due to this office. There will NOT be an additional statement mailed to you by this office. _____
- 8) Unless you arrange other terms with this office, your bill must be paid upon receipt of notification. Any balance over 30 days will be assessed finance charges at rates allowed by law. _____
- 9) Due to excessive processing fees, credit card payments taken by phone (non-swipe) will be assessed the convenience fee of 2% of charges. _____
- 10) The fee for soft tissue/ massage therapy can not be applied to your deductible, but does qualify under FSA/MSA/HSA account guidelines. Non-Minnesota policies may reimburse through your home plan, which is the patient's responsibility to file. _____
- 11) You are responsible for paying any fees associated with missed or late-arrival appointments. Insurance companies never pay those fees. _____

If you have questions about your EOB from BCBS please call them promptly.

I have read, understand, and agree to abide by the information stated above.

Name (please print)

Signature

Date