Request to Bill Insurance and Financial Agreement

I request for Castiglione Chiropractic Centers Inc. to bill my health insurance. I acknowledge and understand that I am responsible for all the charges for the services rendered to me at Castiglione Chiropractic Centers Inc. I hereby agree to pay my insurance deductible and / or co-payment as services are provided.

Although I have requested Castiglione Chiropractic Centers Inc. to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time (90 days from date of service). If for any reason any portion of my bill is not paid within 90 days of date of service by my insurance, I agree to pay the bill myself with a minimum office fee of $75/visit if insurance has not paid.

I have read and understand the financial agreement as detailed above. By my signature below I agree to abide by the terms of the financial agreement.

_____
Please Print Your Name

_____ Exp _____/_____ Sec __ __ __
Credit Card: Visa, MC

_____ _____
Signature Date