WELLCARE
CHIROPRACTIC CENTER

230 Lowell Street, Wilmington, MA 01887

(978) 658-7700 • (978) 658-7703 fax

Insurance Assignment Policy Statement

You have selected to use your insurance benefits to assist in your financial obligation to Wellcare Chiropractic Center (WCC).

At WCC, we offer the option of **insurance assignment** strictly as a courtesy to our members, and, as such, our members must understand and agree to the following:

1. You are considered a cash member until you bring in your insurance card and this office both qualifies and accepts your coverage.

2. While we make every attempt to call and verify benefits on your behalf, the benefits quoted to us by your insurance company are not a guarantee of payment. You are ultimately responsible for full payment for any and all services rendered.

3. That co-insurance/co-pays/deductibles must be paid at the time of service, or at the end of each and every week.

4. That if your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in your recovery of your claim, and as such time after 90 days you are solely responsible for payment in full for any outstanding balance.

5. That in the event you discontinue your program of care prior to the doctor's consent, you are responsible for payment in full of any outstanding balance, and the courtesy of insurance assignment is immediately discontinued.

6. That in the case of a managed care policy where there is a built-in limitation of visits and fees, members must understand and agree that they are required to complete the recommended series of visits and be totally responsible for payment of services rendered at regular fees or set by secondary/medical discounted plan.

7. ***We have a minimum 12 hour cancellation notice. Missed appointments or cancellations made less than 12 hours are subject to a $25 missed appointment fee that is NOT covered by your insurance.***

This *Insurance Assignment Policy* must be followed. Your signature is an acknowledgement that our office has explained the policy to you, and that you understand it, and you accept full financial responsibility.

I have read and understand this policy.

Member Name (please print)	Signature *(Guardian if member is under 18)*	
Guardian Name (please print)	Relationship to Patient	Date