

**Brentwood Chiropractic
Financial Responsibility Agreement**

Patient Name: _____

Date of Birth: _____

Thank you for choosing Brentwood Chiropractic for your healthcare needs. Receiving care with us comes with a financial responsibility to ensure timely payment for services provided.

Insurance and Billing:

- We can assist by verifying your insurance benefits and submitting claims on your behalf, but you are ultimately responsible for payment.
- Any deductible, co-payment, or co-insurance required by your insurance plan is due at the time of service.
- If your insurance denies coverage for any reason, you are responsible for the unpaid amount.
- For out-of-network insurance, you may request a Good Faith Estimate (GFE) of expected charges. If your bill exceeds the estimate by more than \$400, you can dispute the charges at <https://www.cms.gov/nosurprises>.

Standard Fee Schedule:

- Exam: \$35-\$52
- Consultation: N/C
- Adjustment: \$52

By signing below, I acknowledge that I have read and understand my financial responsibility for services rendered by Brentwood Chiropractic. I certify that the information I have provided is accurate, and I authorize my insurance carrier to pay benefits directly to Brentwood Chiropractic.

Patient Signature: _____ **Date:** _____

Guarantor/Guardian Signature: _____ **Date:** _____

Responsible Party for Payment:

- Self
- Other

Name: _____

Relationship to Patient: _____

Address: _____

Phone Number: _____

Insurance Policy Holder Information (if different from patient):

Policy Holder Name: _____

Date of Birth: _____

Address: _____