



RABO HEALTH AND WELLNESS

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We have prepared the following check list in order to help our patients determine their responsibility toward payment for chiropractic services. Please check the statement that applies to you and sign at the bottom.

_____ **Medicare:** I am eligible for Medicare. I understand that Medicare could pay for manipulation of the spine, x-rays or exams if deemed a medical necessity. I also understand that Rabo Health and Wellness will courtesy bill Medicare for me. I have read and signed the Medicare ABN and I am aware that I am responsible for paying for my services whether Medicare pays or denies my claims. It has been explained to me that Rabo Health and Wellness does not accept assignments; therefore, any services paid by Medicare will go directly to me, the patient, and not to Rabo Health and Wellness.

_____ **Private Pay:** As I have no insurance, or third party liable for my health care expense, I agree to assume all responsibility and to keep my account current to the financial arrangements made for payment that is suitable to all parties.

_____ **Insurance Coverage:** I am aware that Rabo Health and Wellness is not contracted with my insurance company and for that reason I have decided to pay in full for the amount of my care in their office. Rabo Health and Wellness can never determine or verify 100% of my anticipated coverage, therefore they will not offer any advice on my insurance benefits. Rabo Health and Wellness will supply an itemized statement to me each month as a courtesy that I can send to my Personal Health Insurance and if the insurance deems necessary, they will reimburse me. If I ever need additional insurance statements from Rabo Health and Wellness or help with insurance questions all I need to do is ask!

_____ **Automobile Accident:** I understand that Rabo Health and Wellness does not hold open balances for automobile accidents with third party claims. I understand that you will bill my personal Auto Insurance for services rendered if med-pay is available. I understand I am responsible for any unpaid balances due at the time I am released for my case.

_____ **Personal Injury:** (Falling, slipping, etc.) I understand I am responsible for the total bill for services rendered. I am aware that Rabo Health and Wellness is not contracted with my insurance company and for that reason I have decided to pay in full for the amount of my care in their office. Rabo Health and Wellness will courtesy bill for me and any payments will be sent to the policy holder.

We believe the clear definition of our financial policy will allow us to all concentrate upon the most important issue of your health and well-being!

***** A 1.5% monthly late charge will be applied on all unpaid balances over 60 days*****

Signature: _____

Date: _____

In the event I discontinue my Chiropractic Care, my bill is due in full immediately!