HUDSON FAMILY CHIROPRACTIC, PHYSICAL THERAPY & ACUPUNCTURE

BLUE CROSS / BLUE SHIELD PATIENT'S ACKNOWLEDGEMENT OF RESPONSIBILITY: Please read thoroughly

BC\BS often sends checks to the patient rather than directly to our office. These checks are payment for services rendered in our office, not a refund or any sort of funds for you to keep. **Patient initials** ______

BC\BS often will limit communication with an out of network provider. If there is a claim or payment in question it is your responsibility to help get us paid. **Patient initials ______**

PAYMENT OPTIONS: PLEASE CHOOSE ONE

_____ I prefer to bring checks and EOB's (explanation of benefits) into the office. I understand that if I do not bring them within 10 days of receipt my credit card will be charged.

_____ I prefer to deposit checks and charge the same amount (+ 3% processing fee) to my credit card. I understand that I still have to bring in or email EOB's for proper accounting.

CREDIT CARD # ____ (VISA, MC, DISCOVER)

EXPIRATION DATE ______________________ SECURITY CODE ____________

SIGNATURE _____________________________________ DATE _____________________________