Jonathan Vahue, D.C.
Healthy Family Chiropractic
1850 Whites Rd., Ste. 5
Kalamazoo, MI 49008
Phone: (269) 567-4111
Fax: (269) 567-4113

Financial Responsibility

Patient Name: ________________________________ SSN:______-______-______
Please print legibly For Insurance Purposes

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company. I also understand I will incur and be responsible for a late fee of $3.00 each month my account carries a balance.

________________________ ____________
Patient's Signature Date

I have read the Healthy Family Chiropractic office policies and will honor them:

_____________________________________ ____________
Patient's Signature Date

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward total charges for professional services rendered by this clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

_________________________ ____________
Patient's Signature Date

I acknowledge that there may be services that may not be billable to my insurance. If I elect to have those services rendered, I understand those charges will be responsibility. I will pay for said charges at the time of service unless payment arrangements are made.

_________________________ ____________
Patient Signature Date

Each month, our office sends all statements/invoice electronically to the e-mail address on file. If you prefer a mailed statement/invoice, we are happy to provide that for free.

☐ I prefer to receive my monthly statements via USPS mail

_________________________ ____________
Patient Signature Date