**RUMEL LLANTADA, DC CCSP**

**5252 BALBOA AVENUE SUITE 701**

**SAN DIEGO, CA. 92117**

**drrumel.office@gmail.com**

**(858)384-6556**

**FINANCIAL AGREEMENT**

**HEALTH INSURANCE**

***We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office I would like to explain how your medical bills will be handled.***

**Explanation of Insurance Coverage and Financial Responsibility**

**Most insurance companies cover Chiropractic care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible, percentage of coverage for Chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balance in this office. We will do our best to verify your insurance coverage, but verification of coverage is still not a guarantee of payment and we will bill your insurance company(ies) in a timely manner for you.**

**Assignment of Benefits**

**I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled to my physician Dr. Rumel Llantada, DC. I also hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payments directly to Dr. Rumel Llantada, DC for medical services rendered to myself and/or my dependents. I understand I am responsible for any amount not covered by my insurance.**

**Release of Information**

**I hereby authorize Dr. Rumel Llantada, DC (1) to release any medical information necessary to insurance carriers regarding my illness and treatment for the purpose of processing insurance claims generated in the course of examination and/or treatment. I also allow a photocopy of my signature to be used to process insurance claims for the period of 24 months.**

**A photocopy of this assignment is to be considered as valid as the original.**

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**Patient/Responsible Party Signature Date**