Lissa A. Grannis, D.C., DACS

ALL NEW PATIENTS

Please Initial Next To Your Method Of Payment

_____**CASH PATIENT**: Payment is expected at the time services are rendered. This allows you a 15% discount for your adjustments. We accept Visa, Mastercard & Debit cards.

_____**INSURANCE PATIENT**: You need to provide our office with your insurance information and a completed claim form. We will bill your insurance as a courtesy to you; with the understanding that you are ultimately responsible for your account in our office.

_____**MEDICARE PATIENT**: Medicare does not pay for X-rays or exams, however, Medicare requires x-rays before they pay for Chiropractic care. Therefore, you need to pay for your x-rays at the time of service. You are responsible for non-covered services and supplies, exams, & etc. You are responsible for your yearly deductible or co-pay.

_____**P.I. PATIENT**: It is your responsibility to provide our office with any and all insurance information; IE: PIP, third party, health insurance, etc. We need all claim numbers and insured persons names, address, and phone numbers. You are responsible for payment to our office for any services rendered.

_____**P.I. PATIENT WITHOUT PIP**: It is our policy that the patient pay $10.00 at each visit to cover the finance charge that will be added to your balance. This finance charge will not be written off and it is your responsibility to pay it.

_____**LABOR & INDUSTRIES**: You are responsible for filling out Labor & Industries long form or the form for Self-Insured L&I. You also have to have an accident report filed with your employer. If you are transferring care from another physician, we have transfer cards available. If your claim is not accepted, you will be responsible for your account balance.

I understand that by making an appointment I am reserving time with the doctor or massage therapist. If I do not cancel this appointment, I can be charged for her time.

Finance Charges of 1% will be added to past due accounts.

I have read and fully understand all of the above.

Patient Signature_____ Date:_____

Witness Signature_____

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Lakewood, WA 98499-8108