Zimmermann Chiropractic and Wellness Center

700 Lake Avenue, Suite 3
Manchester, NH 03103
(603) 668-7070

PATIENT INSURANCE, PAYMENT AND OFFICE INFORMATION

- Thank you for choosing Zimmermann Chiropractic and Wellness Center, LLC for your chiropractic care. We look forward to meeting you and to help make a positive improvement in your health. Please make every effort to be on time for your appointment and we will work hard to stay on schedule as well
- **Payment is due at the time of your visit.** If balance exceeds $150 and payment assistance has not been set up then care may be terminated at the discretion of the office.

- **Insurance deductibles and co-payments are due at each visit to the office.** It is not the responsibility of this office to verify your insurance. **You are ultimately responsible for payment of your care.** You should contact your insurance carrier if you have questions about your specific benefits. Secondary insurance assignment or submission is not the responsibility of this office. We do not accept or offer these options.

- **If your insurance claim has not been paid within 30 days of submission, you are responsible for taking an active role in the recovery of the office charges.** If the claim is denied or 90 days has passed since claims submission, you are immediately responsible for the outstanding balance and agree to pay it within 10 days.

- **We do contract with many insurance carriers, but this does not insure payment or eliminate your financial responsibility for charges outside the contract provisions.**

- **Missed Appointment Fees: I agree to pay a $75 fee if I miss my initial appointment or cancel with less than 24 hour notice**. **I agree to pay $25 for all missed appointments or cancellations with less than 24 hour notice.**

- **By signing this form I give Zimmermann Chiropractic & Wellness Center, LLC permission to release any information required to process my insurance claim and share my health information with my health care providers as needed. I also agree that in case of non-payment to reimburse the office in full for my charges, I will pay for any attorney fees, court fees, etc. involved in any collections process for my non-paid claims.**

_____ _____
Signature Date

_____ _____
Witness Date