Benessere Chiropractic, Massage and Fitness, LLC
295 W. Broadway
Eugene, OR 97401
Ph: (541) 636-3358 F: (541) 636-3098

Insurance Agreement

By signing this agreement, you agree to assign your insurance benefits to Benessere Chiropractic, Massage and Fitness, LLC (Benessere). Benessere agrees to accept assignment of your insurance benefits. If benefits are not assignable or where your payment of benefits is sent directly to you regardless of assignment, you agree to submit any payments received by you, along with the explanation of benefits, to Benerssere within 10 days of receipt unless you have paid for the services in full at the time of service. In no case will an assignment relieve you of your obligation for payment of services received from practitioners at Benessere. Your insurance policy is a contract between you and your insurance company. Benessere is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Benessere is your responsibility whether or not your insurance company pays for services provided. Benessere will make every effort to ensure that your insurance company properly processes your services for payment. In some circumstances we may require your assistance in the billing process. If your insurance company has not paid your account in full within 60 days and you do not assist us in billing your insurance company in a timely manner, the balance will be automatically transferred to your account and full payment will be due immediately.

Declaration

I clearly understand that all insurance coverage is an agreement between my insurance carrier and myself regardless of the type of policy. It is my responsibility to read and understand the benefits of my insurance policy. If Benessere agrees to bill my insurance company for services provided to me, they are doing so strictly as a courtesy to me. I agree to provide Benessere with insurance company information and insurance policy information. I agree to assign my insurance benefits to Benessere. I authorize Benessere to release my medical information that is required by my insurance company for satisfaction of billing and payment requirements. Benessere will provide all information pertaining to me that is necessary to aid in insurance reimbursement for services provided. I understand that if my insurance company denies payment for services rendered to me by Benessere, I am ultimately responsible for any unpaid balances. I also agree that any monies received by Benessere will be credited to my account. I also agree to pay for all services provided to me by Benessere that may not be included in my insurance policy explanation of benefits.

Patient's Name _____DOB: _____

Patient's Signature_____Date: _____

Person Authorizing Care (if different from patient) Please print and sign:

_____Date: _____

Relationship to insured_____