South Boulder Healing Center, PLLC

4150 Darley Ave, Suite 6 • Boulder, CO 80305 • Ph: 303-499-5000 • Fax: 720-500-6085

PATIENT / CLAIMANT _____

PATIENT INSURANCE CARRIER _____

CITED DRIVER INSURANCE CARRIER _____

DATE OF ACCIDENT _____

☐ I have a **med-pay policy** on my automobile insurance policy, and I understand that my auto insurance company will be billed directly for services rendered in this office. After the med-pay limits are reached, I understand that I will be responsible for payment of all charges at the time of service until I am discharged from care from this office.

☐ I do not have a med-pay policy, and I understand that my **major medical health Insurance** will be billed directly for services rendered in the office. I am responsible for any co-pay or percentage required by my health insurance policy at the time of service, and ultimately for any remaining balances that the insurance does not cover.

☐ I do not have a med-pay policy or health insurance coverage for injuries related to this accident. I understand that I am **responsible for 100% of charges** incurred at the time services are rendered.

☐ I have retained an attorney, and there is a signed and **executable lien** on file in this office. I agree to pay a co-payment of 50% at the time of service. South Boulder Healing Center, PLLC will defer collection of any remaining balance due until settlement of my case.

In the event the automobile insurance carrier fails to pay for services for this injury or condition, or it is determined the injury or condition is not a result of this accident; I understand that I am responsible for any remaining balance due.

_____ _____

Name printed Date

_____

Signature