



Patient Financial Responsibility Disclosure and Acknowledgment

No Fault Insurance Disclaimer:

Please be advised that we will attempt to bill your claim according to the No Fault Insurance information that you have provided to us. However, if we are unsuccessful in obtaining payment through No Fault, for whatever reason, we will then bill your personal insurance company for reimbursement. If you do not provide Proactive Chiropractic, PLLC with your personal insurance information, you will be personally responsible for payment of your services.

Your signature below acknowledges that you have been informed of your responsibilities regarding payment.

Patient Signature: _____ Date: _____

Responsible Party Signature (if patient is a minor): _____ Date: _____