TO ALL OF OUR BLUE CROSS/BLUE SHIELD PATIENTS

We would like to welcome you to our office and assure you that we are committed to providing you with the best possible care. Please be advised that our office is non-participating with Blue Cross/Blue Shield of _____ _____.

All payments for services rendered by our office will be mailed directly to you. You are responsible to pay our office when these checks are received. Payment arrangements for these services after Blue Cross/Blue Shield has paid are not acceptable.

We also request that you provide us with a copy of the explanation of benefits that comes with your checks so we may record your account properly.

Thank you for your cooperation.

Sincerely,
Atlas Chiropractic Center

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE WRITTEN RESPONSIBILITY ON MY PART AS YOUR PATIENT.

Patient Signature: _____ Date: _____

In the event that payment from Blue Cross/Blue Shield is not received in this office within _____ days of issuance of said payment to me by Blue Cross/Blue Shield, the following credit card will be charged in the amount of the payment received:

Credit Card: American Express: _____ MasterCard: _____ Visa: _____

Card holder Name: _____ Acct# _____

Exp. Date: _____ Authorized Signature: _____
(required)

Atlas Chiropractic Center 4131 W. Thunderbird Rd. Phoenix, AZ 85053 (602) 938-8868