WHITE MOUNTAIN
Chiropractic & Rehabilitation

1102 Route 119 Rindge, NH 03461
Tel: 603.899.5153 Fax: 603.899.5173

5 Dark Lane New Ipswich, NH 0307
Tel: 603.878.5387 Fax: 603.899.5173

140 Edmond Ave Portsmouth, NH 03801
Tel: 603.422.9220 Fax: 603.899.5173

INSURANCE AND TIME OF SERVICE PAYMENT

Our office is pleased to accept your insurance plan.The copay, deductible and any amount that is not paid by the insurance company are the patient's responsibility. The patient will be billed for any balance not paid by the insurance company within 90 days, unless other arrangements are made with White Mountain Chiropractic & Rehabilitation.

Services or therapies that may not be covered, specifically by **Medicare**, include but are not limited to:

New Patient Initial Exam/Re-exam
Physiotherapy (Heat, Cold, Electric Muscle Stimulation)
Therapy Extremity Chiropractic Adjustment
Rehabilitation Exercises
Soft Tissue
Taping

Estimated Time of Service cost for these **non-covered services/therapies may range from $5.00-$45.00**

TIME OF SERVICE (TOS) DISCOUNT

Whether your insurance covers chiropractic services or not, White Mountain Chiropractic & Rehabilitation offers a Time of Service (TOS) Discount to everyone. In order to qualify for this discounted payment option, all fees must be paid the same day the services are provided (at the discounted rate). If you would like to be reimbursed for the TOS amount by your insurance, it is your responsibility to submit the documentation.

ASSIGNMENT OF INSURANCE PROCEEDS

If you do have insurance, by agreeing to this assignment, we will direct your insurance company to make payments for your chiropractic, physiotherapy, physical rehabilitation or any other reimbursable treatment or evaluations you receive directly to White Mountain Chiropractic & Rehabilitation.

In exchange for services and supplies rendered, I do assign to White Mountain Chiropractic & Rehabilitation any insurance proceeds, including accident and health insurance, auto insurance benefits and bodily injury claim awards up to the amount of any unpaid balance on my account. In giving this assignment, I acknowledge that I am responsible for all charges to my account.

Patient Name _____ Patient Signature _____ Date _____

If Patient is a Minor,

Parent/Guardian Name _____ Relationship to Patient _____ Date _____