

Neal A. Cross, D.C.
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The Healing Arts Center
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712-792-4600

Signature on File

I hereby agree that I have read and fully understand the financial policy.
I hereby agree that I have read and fully understand the privacy notice.
I authorize use of this form on all my insurance submissions.
I authorize release of information to all my Insurance Companies.
I understand that I am responsible for my bill, whatever the insurance company does not cover I will pay in full.
I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
I authorize payment direct to my doctor.
I permit a copy of this authorization to be used in place of the original.
I understand if I do not understand my bill I will ask questions immediately to resolve the concern.
I authorize the doctors and staff to administer treatments as needed.
When I am given nutritional supplements, I know it is my responsibility to ask questions if I do not understand how to take them.

Medicare Patients: I understand that there is a \$135.00 calendar year deductible and am responsible to pay that until met, thereafter Medicare will pay for the **adjustment only**. Any remaining balance will also be my responsibility.

(Initial)_____ I allow The Healing Arts Center to contact me by phone, in writing, via postcard, or by leaving a message at home or work.

Name_____

Signature_____Date_____