RASMUSSEN CHIROPRACTIC CENTER
200 EAST LANIER AVENUE
FAYETTEVILLE, GA 30214
PHONE: 770-461-8781 Fax: 770461-5079

PERSONAL INJURY FINANCIAL AGREEMENT

The state of Georgia is a no-fault state. This means that if you are involved in an auto accident, even if the accident is not your fault, each person is responsible for their own medical bills until you file against the other driver's insurance in a settlement. We **cannot** submit your medical claims to the **other** insurance carrier because they **will not pay us directly**. They will only pay you upon a settlement.

If you have MED PAY on your Automobile Policy, we suggest that you use your MED PAY to pay for your treatment. MED PAY is a medical insurance part of your Automobile Policy that you pay an extra premium for, that covers you in case you are injured in an accident and it will, most of the time, pay your bills 100% up to the amount of MED PAY limit that you have on your policy. MED PAYS can range from $1,000 up to approximately $10,000. That way, especially if the other driver does not have insurance, you are covered for treatment of injuries if you are involved in an accident. If the accident was not your fault, your Automobile insurance carrier cannot, by law, raise your premiums, cancel your insurance, fault you in any way or discourage you from using your MED PAY if you decide to use it to pay for your medical bills regarding an accident.

If you do not have MED PAY on your Auto policy, we may file your claims with your Major Medical Carrier. Major Medical Carriers will not pay 100% of your bill because we are in network with most Major Insurance Carriers and those carriers require us to discount our fees.

This is to notify you in writing that, due to the extensive paperwork, evaluation and documentation required in Personal Injury cases, this office will not honor the discounts designated by your Major Medical insurance. The balance that your MED PAY and/or Major Medical does not cover is your financial responsibility. We will notify you of the balance of your account so that you may pay out of pocket or inform us of your attorney representation so that we may be paid upon the settlement of your case with the other driver's insurance carrier.

If you do not have insurance, you will be required to pay for services rendered at the time of service without attorney representation. **If you have an attorney**, please notify us of their contact information and sign a medical authorization with their office so that we may communicate with them.

Please sign and date below acknowledging that you have read and accept these terms for your treatment. If you have further questions, one of our staff members will be happy to speak to you.

I have read and understand my financial responsibility for my treatment.

Patient name(printed)_____

Patient Signature_____Date_____