



# JOAN MARGARET, D.C.

Chiropractor & Applied Kinesiologist  
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## LABRYS HEALTHCARE CIRCLE FINANCIAL POLICY

Welcome to Labrys Health Care Circle! According to our policy, fees for all services, including examinations, treatments, massage, orthopedic supports, nutrition and educational supplies are payable at the time services are rendered. We accept cash, money orders or checks and Visa and Master cards.

### PLEASE CHECK THE FORM OF PAYMENT THAT APPLIES TO YOU:

- Self-Payment.** If you need a receipt for tax or other purposes, we'll be glad to give you one.
- Health Insurance.** We currently do not bill individual's health insurance, but we would be happy to give you a superbill to send into your insurance company. A superbill will include your diagnosis, plus dates and charges for your office visits. You are responsible for knowing such details as number of visits allowed per diagnosis, or per calendar year, and informing the office of your needs. Tell us if you need your receipt to exclude costs for food supplements, or other costs.
- Auto Insurance.** Most auto insurance policies provide "Med pay" coverage to the policyholder and to covered dependents for expenses resulting from an accident regardless of which driver is determined to be at fault. It is your responsibility to contact the adjuster at your insurance company to determine how much med-pay coverage is on your policy. Please notify us of this amount and keep track of your total medical expenses. If your bill from treatment exceeds the amount your insurance company covers, you are responsible for paying any remaining balance. If an attorney is handling your case, please let us know.

After you've provided us with your insurance information, we will phone to verify coverage in your case, please let us know. Ultimately, you are financially responsible for all services rendered and products received in this office whether or not your legal case is settled to your satisfaction.

**Other:** .....

**AGREEMENT TO PAY:** I agree to pay for all services rendered and understand that payment is expected on the day of treatment unless previous financial arrangements have been made.

Signature: ..... Date: .....