



**Kershen Chiropractic, P.A.**

Dr. Russell R. Kershen

Dr. Tyson Neill

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Phone: (806)655-8777

Canyon, Texas 79105

Fax: (806)655-8790

[KershenChiropractic.com](http://KershenChiropractic.com)

**PAYMENT OPTIONS:** VISA, MASTERCARD, DISCOVER, DEBIT CARDS, CHECKS & CASH

The following approved plans for paying for your care at Kershen Chiropractic.  
(please check one)

\_\_\_\_\_ 1. I have insurance and will assign my benefits to Kershen Chiropractic. **I will pay my copay each visit and any other amount not covered by my insurance company.** (See ins. Assignment below)

\_\_\_\_\_ 2. I have insurance, **but I choose to pay my account in full each visit** and receive the 25% time of service discount on office visits, adjustments, and therapy: and 15% on x-rays from Kershen Chiropractic's fee schedule. I will then file my own insurance.

**YOU MUST PAY AT TIME OF SERVICE TO RECEIVE DISCOUNT!** If my insurance discount is greater than the time of service discount, then the insurance discount may be used. (There will only be one discount allowed per visit.)

\_\_\_\_\_ 3. I do not have insurance. **I will pay my account today and earn a 25% time of service discount on office visits, adjustments, and therapy: and 15% on x-rays from Kershen Chiropractic's fee schedule.**  
**YOU MUST PAY AT TIME OF SERVICE TO RECEIVE DISCOUNT!**

\_\_\_\_\_ 4. **Family Plan:** I choose the family plan prompt payment discount of 10 adjustments for **\$299.00**. I understand that this plan expires one year from the date of purchase. After one year, any remaining balance and used visits will revert to the time of service discount fee schedule.

\_\_\_\_\_ 5. Auto Accident: **Additional paperwork required!!**

\_\_\_\_\_ 6. Workers Compensation Claim: **Additional paperwork required!!!**

Assignment and Release (For insurance purposes only)

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Kershen Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that **I am financially responsible for all charges** whether or not paid by insurance. I understand that there may be some unforeseen procedures or products that insurance does not cover and I agree to pay for them in full when billed. I hereby authorize Kershen Chiropractic to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Patient's Name ( PLEASE PRINT)

\_\_\_\_\_  
Patient's Signature (Parent or Guardian if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Policyholder's Name

\_\_\_\_\_  
Policyholder's SS#

**KERSHEN**



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