Fee Agreement (Mar23/21)

Manitoba Health (MHSC):

Have you seen a different Chiropractor THIS year?
If YES, please list the number of treatments you had and at which clinic. If unsure, let us know, we can phone them to find out.

Name Of Chiropractor Visited This Year:	Number of Treatments You Had There:

Manitoba Health covers a portion of the first 7 treatments of the year. For those of you with a valid MHSC card and unused MHSC visits, Manitoba Health pays $10.00 and you pay the remainder. Once you have used your 7 visits, your Manitoba Health coverage has run out for that fiscal year. The total treatment fee will then go up in price by $10.00.
You will be responsible for paying that at the time of service.

If you have received Chiropractic treatment in the current year and have not listed the treatments above, or MHSC denies any claims due to inaccurate information you will be charged for any outstanding balance.

If your Manitoba Health card changes for any reason (i.e. Address, Marriage, etc.) please let us know as soon as your new card arrives in the mail.
If you do not have your Manitoba Health card at your initial exam, we will not be able to bill Manitoba Health for your treatment.

$50.00 Fee for Missed Appointments and/or Short Notice Cancellations:

I understand that I will be billed $50.00 for:

a. Any Missed Appointments without given notice.
b. For Short Notice Cancellations where you do not provide us with adequate notice for a cancellation.

*Missed appointments will result in the need to have a credit card on file or the ability to no longer schedule appointments.

Insurance/Direct Billing:

We direct bill to most insurance companies, however sometimes technical difficulties occur, and we may need you to pay for your treatment and submit the receipt yourself.

CD Copy Of X-Ray Imaging: (ONLY IF NEEDED)

If you have x-ray imaging done by Dr. Rick Corbett/Winkler Chiropractic and would like a copy:
I understand that there is a $25.00 fee paid in **CASH** for a CD copy of any imaging if needed/wanted.

Purpose Of Examination:

During the examination, the chiropractor will be performing tests that may cause discomfort.
I agree to proceed with such an examination.

Please sign below to confirm that all information provided is correct, and that you understand the terms of this agreement.

_____ _____

Print Name Above: Today's Date:

_____

Sign Name Above: