Patient Financial Policy

Thank you for choosing us as your chiropractic physician's office. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, OR DISCOVER.

REGARDING INSURANCE:

We may accept assignment of insurance benefits after your insurance has been verified. However, we do require payment (Co-pay and any charges not covered by your insurance policy) to be paid at time of service. The balance is YOUR responsibility, whether your insurance company pays or not. All insurance carriers make clear that verification of coverage does not guarantee payment of benefits. We cannot bill your insurance company unless you give us your insurance information and all relevant personal information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, the balance will automatically be transferred to you.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS:

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. We reserve the right, at our discretion, to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments, and/or by calling 24 hours in advance so another patient may be fit in.

PAYMENTS:

Unless another arrangement is agreed, all co-pays and deductible are due at the time of treatment. All payments are due within 30 days of the monthly billing date. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other insurance. If payment has not been received, the patient is in default and is responsible for collection, filing, court or attorney fees incurred in attempting to collect this amount or any future outstanding account balances.

ASSIGNMENT OF BENEFITS

In consideration of your undertaking to treat me, I hereby agree to the following:

1.You are authorized to release any information you deem appropriate concerning my physical condition to my insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by you or any member of your staff acting on your behalf.

2. I authorize the direct payment to you of any sum I now or hereafter owe you by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services. I also authorize the direct payment to you by my attorney out of the proceeds of any settlement of any claim based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, it is my understanding that I am responsible for your charges in full, and payment for services rendered will be made on a current basis and my account paid in full immediately.

4. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

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Patient's Signature (or Parent/Guardian, if a minor) Date

By signing, I understand and agree to this Financial and Office Policy.