

# FINANCIAL POLICY

We are committed to providing you with the highest quality of care and we believe that it is important for you to clearly understand your financial commitment to this office so we may focus on what is most important – your health. In order to do this, you must agree to the following:

- 1) That you, the patient or legal guardian of the patient is personally responsible for all services rendered to you in this office. Any insurance policies are contracts between you and the insurance company. We can only call the insurance company and go by what the person on the phone tells us about your coverage. We strongly suggest that you personally confirm with your insurer what your benefits and limitations are as soon as you can.
- 2) That you are considered a cash patient until you produce your health insurance card and this office verifies and accepts your insurance coverage.
- 3) Unless you provide evidence of insurance, payment is expected and due at the time services are rendered.
- 4) That this office does not file for or accept co-payments from secondary insurance carriers.
- 5) That your co-payment must be paid at the time of your office visit and that all deductibles must be paid in full. **Our contracts with HMOs and PPOs require that this be strictly adhered to.**
- 6) That if your insurance company has not paid a claim within 45 days of submission, you are responsible for taking an active part in the recovery of that claim. After 90 days, you will be responsible for payment in full for any outstanding balance.
- 7) You may not have a PATIENT balance of over \$100 at any time.
- 8) All patient accounts 30 days past due will accrue **1 ½ %** interest per month (**18% annually**).
- 9) The billing fee for overdue accounts is \$2.50 for the initial bill and \$4 for each bill thereafter which will be sent every 14 days until such time as the account is paid in full.
- 10) All accounts over 45 days past due without financial arrangements will be turned over to our collection agency. **You are liable for all legal and collection fees.**
- 11) Any patients who require FMLA forms to be filled out for their employer will need to schedule a separate consultation so that the doctor will be able to accurately complete your paperwork. The cost of this consultation is \$25 and it is generally not covered by insurance. This fee must be paid in advance and we will submit the visit to your insurance company for you for possible reimbursement. All request for forms to be completed require a 48 hour notice.

I have read, understand, and agree to the above noted policies.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (print) \_\_\_\_\_

Witness \_\_\_\_\_

**INFORMED CONSENT TO TREATMENT AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me or on the patient named below for whom I am legally responsible for by the Doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working for, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below, or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel regarding the nature and purpose of chiropractic adjustments and procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do expect the doctor to exercise judgement during the course of the procedure which the doctor feels, at the time, based upon the facts known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to discuss or ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and for any conditions in the future for which I seek treatment.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\*I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release information required to process insurance claims.  
\*I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

By my initials \_\_\_\_\_, I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance unpaid by the insurance company.

**\* I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.**

\_\_\_\_\_ DATE \_\_\_\_\_

**Patient, Parent, Guardian or Patient's legal representative Signature**

\*Our policy requires payment in full for all services rendered at the time of the visit unless other arrangements are made with the office manager.

**How will you be paying for today's visit?** \_\_\_\_\_ CASH \_\_\_\_\_ CHECK \_\_\_\_\_  
CREDIT CARD \_\_\_\_\_ GIFT CERT \_\_\_\_\_ ACCIDENT \_\_\_\_\_