Payment Policy

Thank you for choosing us as your Chiropractic office. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and health insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Please initial after each line stating that you have read and agree to each policy.

- **Insurance.** We participate with select insurance plans, including Medicare. If you are insured by a plan we are not contracted in, payment in full is expected at each visit. If you are insured by a plan we are contracted in, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. _____
- **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. _____
- **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit. _____
- **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. _____
- **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. _____
- **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. _____
- **Returned checks:** There will be a $20.00 fee per returned check. _____
- **Non-payment.** Payment is due in full at the time services are rendered. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial. _____
- **Overdue Accounts.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless

otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. _____

- **Missed/Canceled appointments.** If there have been three missed appointments within the current calendar year, there will be a $35.00 charge billed to the responsible party. After a total of six missed appointments within the current calendar year, there will be a charge of $35.00 billed to the responsible party for each appointment missed for the remainder of the year. **Please keep in mind that our appointments are ten minutes long.** Therefore, if you are ten minutes late or more to your appointment, it will be considered missed. We ask that you give us at least two hours' notice when canceling or re-scheduling an appointment. This allows us to offer your appointment to another patient seeking care. Anything less than a two-hour notice will be considered a missed appointment. _____

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**