LARGE
CHIROPRACTIC
CLINIC

Patient Financial Policy

Your understanding of our financial polices is an essential element of your care and treatment. If you have questions, please discuss them with our Office Manager.

As our patient, you are responsible for all authorizations and/or referrals needed to seek treatment in this office.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. This includes copays, co-insurance, and deductibles. We accept VISA, MasterCard, Discover, American Express, cash, check, and CareCredit.

Your insurance policy is a contract between you and your insurance company. **It is not our responsibility to keep track of your benefits or whether you are about to exhaust your benefits. Patients are expected to monitor this as they would their bank account.** As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, you would be responsible for the balance.

We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

All health plans are not the same, and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for the charges of any services rendered. We cannot be held accountable for any false or misinformation given to our office by you or your insurance carrier.

You must inform the office of all insurance changes and authorizations/referral requirements. **In the event the office is not informed, you will be responsible for any charges denied.**

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fee, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

There is a service fee of $25.00 for all returned checks plus our banks NSF Charge at the time. However, your insurance company does not cover this fee.

Signature Required on Back of Page 

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Witness Signature: _____

Printed Name of Witness: _____ Date: _____

Patient please check one of the below items.

_____Patient received a copy of this financial policy.

_____Patient does not want a copy of this financial policy.