

# ***FINANCIAL POLICY***

## **On The Job Injury:**

Worker's Compensation pays in full for Chiropractic Care. Upon being released from care, a 3-month time period is allowed for settlement of your claim. If a settlement has not been reached within this time period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.

## **Group or Individual Insurance:**

Your insurance is an agreement between you and your insurance company, not between your insurance company and this chiropractic center. As a courtesy to our patients, our office will complete any necessary insurance forms at no charge, and file them with your company to help you collect. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible.

We are not certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. Because of this difference between policies, we expect that each patient who wishes to file insurance claims through this office, pay the insurance policy deductible and the patient's percentage as stated in your policy. (The patient's percentage is usually 20% of covered costs, after the deductible has been met.) Our billing system is arranged with the patient's percentage automatically calculated for your convenience.

## **Patients Without Insurance:**

1. We request that 100% of the first visit be paid at the time of the first visit.
2. For your convenience, payment may be arranged at the last visit of each week.
3. To receive the "time of service discount" you must pay at each visit.
4. We accept checks, MasterCard, Visa or Debit Cards.

## **Medicare:**

We accept assignment from Medicare. The checks are usually sent to our office. The patient is responsible for payment of any non-covered services (for example, X-rays). Our office will complete the necessary forms and file them with the Medicare provider at no charge.

## **Special Payment Instructions:**

Patient's Name: \_\_\_\_\_

Insurance Deductible: \_\_\_\_\_ Deductible as yet unsatisfied: \_\_\_\_\_

Co-Insurance Percentage: \_\_\_\_\_

Notes: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_