# Financial Policy

1. All patients are on a cash basis until their respective insurance coverage, deductible, and co-pay, may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis.

**Insurance**

3. If you have insurance we will gladly file your claim for you to your primary insurance carrier. And if need be we will resubmit a claim one time only. We will not enter into dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. Any disputed or denied claims will be treated as uncovered services and you will be expected to pay such charges in a timely manner.
4. If you have a secondary insurance, we will provide you with the information and assistance necessary for you to file the claim.
5. If you should receive a check from your insurance company during our billing that should have come to us to pay your account, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue a credit to your account.
6. Any services not covered under your insurance coverage will be your responsibility.
7. We are not a mediator between you and your insurance company and we will not enter into any disputes, as your contract is between you and your insurance company.
8. Any accounts payable that do not receive some form of payment for 90 days will be subject to a service charge of $5.00 per month, and will be sent to collections at 150 days unless arrangements have been made. All we require is a call from you and we will be happy to make arrangements.
9. In the event that an account is sent to collections, the responsible party agrees to pay an additional 30% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

**How payment will be made today (please initial)**

_____Cash _____ Check _____Credit Card

_____ Insurance _____ Auto Insurance _____Workman's Comp.

I (we) agree to pay services rendered to the above mentioned patient as the charge is incurred. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient Signature _____ Date _____

Guardian/Responsible Party Signature _____ Date _____

# HIPPA Acknowledgement Form

I hereby give consent to Family Chiropractic Center for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me and for general administrative operations of the practice. I have read the HIPPA Notice of Privacy Practices document from Family Chiropractic Center and understand and agree with what I have read. I am aware that I can ask this office at any time for a copy of their HIPPA Notice of Privacy Practice document and that it may change from time to time for updates and amendments. I understand that I have the right to request restrictions on the use and disclosure of my PHI, but the practice is not required to agree with these restrictions.

You may contact me for appointment reminders, schedule changes, or other needs by the following methods:

**(Please check all applicable ways in which we may contact you)**

❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ U.S. Mail ❑ Email

Patient Signature _____ Date _____

Signature of Parent/Guardian _____ Date _____