Payment Policy

All Payments are due at the time of service.

PLEASE CHECK HOW YOU PREFER TO PAY: Cash____ Check____ Credit Card____ Payment Plan ____

If a financial problem arises, please call for a consultation with your doctor. They will work out a payment plan that will accommodate you. DO NOT interrupt the consistency and intensity of your adjustments or you will lose the correction you have already achieved. This would result in lost time, money, and effort.

Return check fee is $25 in addition to original payment amount.

Payment for all charges, expenses and late fees is due upon receipt. While we will work with your insurer to help see that charges are paid by the patient's insurer to the extent of the patient's coverage, the patient acknowledges that the patient is ultimately responsible for the full account balance, irrespective of any insurance coverage or insurance dispute. Personal patient representatives agree that they, too are as equally liable as the patient. The patient agrees that, in the event the patient's account is placed with a collection agency or law firm, the patient will pay an additional amount equal to 45% of the entire account balance as a reasonable cost of collection or attorney fee, in addition to any court costs. Thanks for making payments promptly.☺

For any balance that remains on your account for more than 60 days, we reserve the right to charge a late fee of $25 per month, to be added to any unpaid balance. This fee compensates us for the additional time and resources expended by us in contacting you about payment, rebilling your account, and similar efforts. Any late fees charged to an overdue account will also become the patient's responsibility. We thank you for making payments promptly, we don't like late fees either.☺

We reserve the right to cap a maximum unpaid balance at $500.00. If payments have not been made by the patient, chiropractic care will be stopped until an agreement is met and payment is made.

Authorization, Assignment and Release

_____(Initial) **AUTHORIZATION TO RELEASE INFORMATION:** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, or doctor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you and I hereby release you of any consequence thereof.

_____(Initial)**ASSIGNMENT OF PAYMENT:** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any monies due him on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim.

_____(Initial) **MEDICARE ASSIGNMENT:** I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration of its' intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

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Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at Advanced Care Chiropractic, P.C. and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of a liability case and as long as you are in the corrective care portion of your visits.

I understand that if it is determined either:

A. That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to Acknowledge an assignment to the doctor; or make other provisions for the protection of the interest of the doctor; Or

B. If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged Services of an attorney:

Then payment of services rendered by the doctor at Advanced Care Chiropractic, P.C. will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

______________________________ ______________ ______________

Patient's Signature Witness_ Date:

Successful Spinal Correction Requires TWO Major Ingredients: TIME and REPETITION