

# CHRISTENSEN CHIROPRACTIC

## PATIENT FINANCIAL AGREEMENT

PATIENT NAME \_\_\_\_\_

CASE # \_\_\_\_\_

I understand that I am responsible for all charges incurred for my care that are determined to be allowable by my insurance carrier. I further understand that if there are limits to my policy, I am responsible for charges incurred beyond the limits of my coverage. Full payment of patient obligation is due at time of service. We accept cash, personal checks, and all major credit cards **except** American Express as forms of payment.

**Please note that every attempt is made to properly verify the limits to your coverage. All out of pocket estimates given are estimates only! For complete benefit limitations, please refer to your policy. Verification of benefits and eligibility does not constitute payment of claims. The patient is ultimately responsible for payment of all services received.**

**All deductibles, co-pays and patient portions will be due on the date of service.**

Christensen Chiropractic will submit all claims for charges incurred by me to my insurance carrier. And I agree to assign my benefits to Christensen Chiropractic. If my benefits are not assignable, I agree to forward any insurance checks that I receive for services provided by Christensen Chiropractic promptly with the explanation of benefits (within 10 days of receipt of payment). As a courtesy, we file your insurance claims electronically to your insurance company.

You are 100% responsible for denied and non covered services, services deemed not medically necessary by your insurance company, pended claims due to lack of patient and/or guarantor information.

Any co-insurance charges for services will be billed after receipt of your explanation of benefits. I understand that any co-insurance amounts identified on my explanation of benefits are my responsibility and that I will be billed for these amounts. If your insurance company fails to pay within 60 days of claim submittal, you are then responsible for payment in full.

**Return Check Policy:** We are happy to accept your personal check, however, if it is returned for any reason, you will be subject to a \$25.00 return check fee that our bank passes along to us.

**We are prohibited from filing your insurance for maintenance care. Maintenance begins when the therapeutic goals of a treatment plan have been achieved and when no further progress is apparent or expected to occur. Since your insurance WILL NOT cover any type of maintenance care, you are ultimately responsible for payment.**

### **Missed Appointments:**

Unless cancelled at least 24 hours in advance, it is our policy to charge \$50.00 per missed appointment. We will not file, nor will insurance pay for this charge so please help us serve you and our other patients better by keeping scheduled appointments or cancelling in advance.

### **Collections of Past Due Balances:**

Any past due balance not paid **within 90 days**, will be reported to the credit bureau and turned over to an attorney or agency for collections. You will be responsible for all charges related to

this collection process. Please keep your account current to avoid any action or blemish on your credit history.

**MESSAGE PATIENTS:** Payment is expected for all massage appointments at the time of service with cash or check only. Massage appointments are made through the Massage Therapist only not through Christensen Chiropractic.

**I have read the above and understand and agree to this financial agreement.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_(Seal)