

## **FINANCIAL AGREEMENT HEALTH INSURANCE**

We would like to take a moment to welcome you to our office and assure you that you will be receiving the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

### **EXPLANATION OF INSURANCE COVERAGE**

Most insurance policies cover Chiropractic care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for Chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage and will bill your insurance company(ies) in a timely manner as a courtesy for you.

### **PAYMENT ARRANGEMENTS (Blue Shield, United Healthcare)**

We require that you pay your co-insurance or co-payment at the time services are rendered. We will bill Blue Shield or United Healthcare as a courtesy for you. We will accept assignment from Blue Shield or United for any payment on services rendered. Any unpaid, "non-allowed" charges by Blue Shield or United will be immediately due and payable. You will be given thirty (30) days to pay for any unpaid, "non-allowed" charges. Any outstanding charges not paid within thirty (30) days will be sent to collections.

### **PAYMENT ARRANGEMENTS (Non-Blue Shield/United Providers)**

We require that you pay for services in full at the time they are delivered. We will provide you with a Super Bill twice a month so that you may submit these to your insurance for direct reimbursement.

### **DELINQUENT CLAIMS**

We require that you will be personally responsible for any delinquent carrier claims unpaid after (60) days.

### **RELEASE OF INFORMATION**

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

### **VOLUNTARY TERMINATION OF CARE**

If you suspend or terminate your care at any time, your portion of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately, will be personally responsible for payment, regardless of your insurance coverage.

We hope this answers questions you might have concerning the financial policies of this office. Once again, we welcome you to our office, and will be glad to answer any further questions that you might have.

***I have read and agree to the above.***

**Patient Name** \_\_\_\_\_

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**