

BARGER CHIROPRACTIC

Welcome to our office. Please read the financial policy carefully so you understand your financial responsibility.

CASH

Charges for services rendered are due at the time of service. Arrangements for discount packages can be made in advance of the services. Any account which is in arrears of 30 days or more, can be charged 2% per month for any past due amounts. If you choose to suspend or terminate your care, any remaining balance is immediately due and payable.

HEALTH INSURANCE

You are responsible to know and understand your own benefit and coverage for Chiropractic care. As a courtesy, this office will verify where possible, but this is not a guarantee of benefits or coverage. Copays are due on the date of service. You may prepay multiple copayments, but no copays will be kept in arrears due to insurance contracts. Any services not covered, including adjustments, therapies, Durable Medical Equipment, etc., services not paid due to lapse or termination of coverage, are due and payable at the time of service or upon receipt of a bill.

AUTO ACCIDENT/PERSONAL INJURY

For any personal injury or auto accident case, services will be paid out of pocket by the patient, who will be reimbursed by his/her own auto insurance at the time of settlement. If you choose to use an attorney, please check with the office for a list of attorneys who have worked for many years with this office.

We do not accept auto insurance coverage or health insurance for a complicated injury case

PLEASE NOTE:

There will be a charge of \$10 each for additional therapies that are not covered by your insurance. This includes private pay/out of pocket, cash packages purchased, Flex and HSA spending accounts.
For No Show or late cancellations on any appointment, there will be a service fee of \$30. To avoid this fee, cancellations must be made 24 hours prior to the scheduled appointment time.

ASSIGNMENT OF BENEFITS

I, _____, hereby certify that I have verified my eligibility for Chiropractic benefits through my insurance plan: _____.

I understand if any of the above is not true, or I am not eligible under the terms of my/my employer's medical plan or insurance policy, I am liable for all charges in full for services rendered, and payment is due immediately upon receipt of a bill for services from Barger Chiropractic. **I understand I am solely responsible for any and all charges, and it is my responsibility to know and understand my insurance coverage, benefits and limitations.** *If I am paying out of pocket, I agree to pay in full for all service rendered by Barger Chiropractic at the time of service, OR as arranged in writing at the time of service.*

I authorize the release of any health information necessary to process my claims. A photocopy of this authorization shall be effective and valid as the original.

I authorize payment of my medical benefits directly to Barger Chiropractic.

I understand I am responsible to pay for non-covered services and or unauthorized services.

I have read and understood the above policies.

Patient signature: _____ Date _____

Patient acknowledges/has seen/understood/refused any information on the HIPPA Privacy Act.