Arlington Family Chiropractic Clinic
FINANCIAL POLICY

Patient Name: _____ Sex: M F Birth date: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

SS#:_____ Home phone #:_____ Cell #:_____ Marital Status:_____

Email:_____ Insurance Co:_____

Thank you for choosing our office as your health care provider. We are committed to providing you with the highest quality lifetime care, so that you may fully attain optimum health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided unless a payment plan is arranged. Our office accepts cash, personal checks and most major credit cards.

Please note: Returned checks and/or declined credit cards will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred up to 35%.

Do you have insurance?

- **As a courtesy to you,** we will process all your insurance claims. Please understand that we will provide an **insurance estimate** to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your chiropractic care provider, our relationship is with you, our patient, not with your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time we provide the services to you.
- Insurance payments are typically received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with regulations and request of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my medical benefits directly to this office. The undersigned hereby authorizes the Doctor to take x-rays or any diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patients needs. I also authorize the doctor to perform any and all forms of treatment and therapy that may be indicated. I understand that responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable as services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

Patient signature :_____ **Date:**_____