Jensen Chiropractic

Patient Name: _____ Patient #: _____

PAYMENT POLICY INFORMATION

Payment for Services will be by: Cash____ Check____ Credit Card____.
Chiropractic services provided in this office are payable the day services are rendered unless other arrangements have been made prior to seeing the doctor.

Note: Patients with insurance plans that have an annual maximum benefit for chiropractic services do hereby consent to paying for service in full once the annual maximum benefit is reached.

1. Patients are personally responsible for all charges. If the staff is unable to verify insurance benefits prior to the end of your first visit, payment is due in full.

2. There will be a $5.00 charge for paperwork above and beyond the normal claims information needed to process group or individual insurances or if more than 2(two) insurances are involved.

3. Payment Plan is available upon approval of credit extension by the Office Manager.
I authorize a credit check if credit is extended.

4. Assignment of Insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office. There will be verification of coverage, however **"benefits quoted are not a guarantee of payment".** Benefits are determined at the time of processing.

5. Any balance remaining after 60 days with no action on the account will be charged an 18% per annual service charge.

6. A collection fee equal to 40% of balance will be added to all delinquent accounts over 90 days past due that have to be sent to a collection agency.

7. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself - not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports at no charge to assist in collecting from my insurance company.

8. If mine is a regular insurance case, I agree to pay a percentage of services as they are rendered. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY:

PATIENT'S SIGNATURE: X_____ Date: _____
(OR GUARDIAN / GUARANTOR)

Witness's Signature: _____ Date: _____