INTEGRITY CHIROPRACTIC FINANCIAL POLICY

Thank you for choosing us as your health car provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

USUAL AND CUSTOMARY RATE
Our practice is committed to providing the best treatment possible for our patients and we charge what are usual and customary rates for our area.

MISSED APPOINTMENTS
Unless cancelled at least 24 hours in advance our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

We accept cash, checks, and Visa/MasterCard. **FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ONE OF THE FOLLOWING APPLIES TO YOU:**

MINORS
The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, cash, or check payment at the time of service.

MEDICAL INSURANCE
We may accept assignment of insurance benefits. We do, however, require the co-insurance portion of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information and an original claim form if required. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full in 45 days, the balance will be due and payable in full by you.

PERSONAL INJURY
Your account will be filed through your health insurance and the med-pay portion of our automobile insurance or homeowners insurance. We require a Doctor's Lien to be signed by both yourself and your attorney (if you have one). We want you to understand that we are treating your condition sustained as a result of your accident. We are not in any way treating your liability claim. All billings submitted to your insurance company and/or attorney is done solely as a courtesy to you. Your account is due and payable within 6 months of release by the doctor. If a check is issued to you for medical care, it is your responsibility to pay your medical claims immediately and in full.

WORKERS COMPENSATION
If your injury is denied as not work related is becomes your responsibility and is due and payable immediately. If you discontinue care without the Doctor's authorization, your account will be due and payable immediately, regardless of any insurance filed. In the even your account becomes delinquent; you will be responsible for any court or attorney fees incurred by this office, in addition to the balance.

We will add a 10% service charge to your case for any balance left on your account after 30 days. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.
I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I have read, understand, and agree to the above Financial Policy.

_____ _____
Signature of Patient or Responsible Party Date