***Huffer Chiropractic***

***307 South Main Street; PO Box 647***

***Jackson Center, OH 45334***

**FINANCIAL POLICY**

We recognize the need for definite understanding between our patients and this office regarding financial arrangements for chiropractic care. We have established the following financial policy in response to those needs. It is our hope that you will understand that these payment collection practices are a necessary part of assuring the financial resources required to provide the best chiropractic care to our patients and community.

**Self Pay / PIFATOS (pay in full at time of service)**

Patient pays all charges in full by cash, check or credit card at the time of service. PIFATOS patients can receive a DISCOUNT up to 40% off charges. Upon payment, the patient will receive a super-bill listing complete details of his/her office visit. The patient will be responsible for submitting this super-bill to his/her insurance company.

**Insurance**

**Personal Injury -**This office will bill the patient's MedPay for treatment related to a personal injury claim. If MedPay information is not provided, the patient will be required to pay for services at the time of visit.

**Medicare-** This office accepts Medicare. Refer to “About Medicare Coverage” to see what is covered.

**Co-pays\Deductibles\Estimated Payment**

Co-payments/deductibles are due at the time of your visit. If we do not know your exact Co-pay or Deductible, we will collect an “estimated payment”.

**Charges and Fees**

Our office charges are base on HIPAA approved CPT (Current Procedure Terminology), HCPCS (Healthcare Common Procedure Coding System and ABC (Advanced Billing Concepts). Our Fees are posted in our office near the Receptionist counter. Fees are changed periodically.

**Payments accepted:**

We accept CASH, CHECK and CREDIT CARDS. Any returned checks will be assessed an additional fee up to $25.00.

**Patient Statements**

Patients will be billed monthly on any money due our office.

**Missed Appointments**

Missed appointments may be charged at $25.00

**Collections:**

Accounts place for collections will be charged additional collection and attorney fees. Accounts may be place for collections if not paid in full after 30 days of first statement.

**Credit Balances**

Patients with credit balances may call our office for a refund.

**Change of PHI (Protected Health Information)**

Please notify our office immediately if there are any changes in PHI, including address, marriage, divorce, dependants, insurance coverage, any other health issues, ETC.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I acknowledge and accept this Financial Policy.

Patient/Guarantor signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: 01/26/2017