ALLEN CHIROPRACTIC CARE, INC.
The doctor's choice for advanced pain relief.

1932 Lee Highway - P.O. Box 16056 - Bristol, VA 24209
Tel: 276.466.CARE (2273) – Fax: 276.466.2214
E-mail: Briggsaln@aol.com www.backdrs.net

Financial Policy and Agreement

Patient Full name (PRINT)_____DOB_____

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided by Allen Chiropractic Care, and the various entities for the patient whose name appears above.

Payment for Service: Our office will inform you of the amount due when you check out. This amount is due at the time of service. As a courtesy to you, well file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

STATEMENT OF FINANCIAL LIABILITY

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of office charges at the time of the visit. I understand that unless otherwise indicated below, I hereby request and authorize Allen Chiropractic Care to bill insurance policies written in the United States, and insurance companies based in the United States, for surgical and other charges for services provided to me, and I authorize payment to Allen Chiropractic Care for all such services.

NOTICE OF LIABILITY FOR "NON-COVERED" SERVICES

I understand that my insurance carrier (whether private, Medicare, or other third-party payer) may deny payment or consider some or all services performed by Allen Chiropractic Care, such as certain types supplies, to be "non-covered," and that I will then be fully responsible for payment of all such non-covered services.

CHANGES TO BILL TO/ PAYMENT INSTRUCTIONS

☐ By checking the box to the left, I hereby direct that The Steadman Clinic SHALL NOT bill my insurance company for services provided to me, and instead I agree to pay all fees for services furnished to me by Allen Chiropractic Care.

PERMISSION TO RELEASE MEDICAL INFORMATION

I authorize Allen Chiropractic Care to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third-party payers or their reviewing agencies, as reasonably necessary to expedite claim processing and procure payment from such parties for services rendered by Allen Chiropractic Care. This authorization is valid for every visit to Allen Chiropractic Care or its affiliates until written notice revoking it is provided. I release Allen Chiropractic Care of all responsibility or liability for use and disclosure of such information, or other information disclosed in compliance with this authorization.

AUTHORIZATION TO SIGN MY NAME ON PAYMENS; TRANSFER OF CREDIT BALANCES.
I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by [Name of office])," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Returned Checks: A $25.00 service charge will be added on all checks returned to us for insufficient funds.

Copies of Medical Records: There may be a charge for completion of this process;

- $1.00 per page for the first 50 pages
- $.50 per page for all other pages
- Clerical fee not to exceed $15.00
- Plus actual postage

No-show Appointments: A fee of $25.00 for a follow up visit and $50.00 for a new patient visit may be charged for all missed appointments not cancelled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may nitify our office of any cancellations by calling the number listed above during normal office hours.

Collection Policy: Delinquent accounts will be forwarded to an Attorney for collection. We will inform you of your account status on your statement. We will attempt to contact you by letter before your account is forwarded.

Questions: We are here to help should you have any questions regarding your statement or insurance.

Signatures: I have read and understand these financial policies.

Patient/personal Representative Signature:_____ Date:_____

PRINT Name of personal Representative:_____

Relationship of Representative to Patient:_____