BACK to HEALTH CHIROPRACTIC CLINIC

DR. ROGER A. MARQUARDT

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OUR FINANCIAL POLICY

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

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD.

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance

We may accept assignment of insurance benefits after your second visit. However, we do require your co-payment to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates

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.

Adult Patients

Adult patients are responsible for full payment at time of service or deductible/co-pay amount according to the terms of your policy and prior approval of this office.

Minor Patients

The parents, legal guardian or adult accompanying a minor are responsible for full payment at time of service or deductible/co-pay amount according to the terms of your policy and prior approval of this office. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at time of service has been verified.

Missed Appointments

Unless notified, at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of 50% of a normal office visit.
Unless notified, at least 24 hours in advance, our policy is to charge for missed manual muscle therapy appointments at the rate of 50% of a normal office visit. Missed appointment charges will be your ***personal*** responsibility and will not be billed to your insurance company.

Please help us serve you better by keeping scheduled appointments, and notifying us promptly of any necessary changes.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

X _____ Date _____

Signature of Patient or Responsible Party

X _____ Date _____

Signature of Co-Responsible Party

X _____ Date _____

Witness