Financial Policy

Thank you for choosing Idaho Chiropractic Group, PLLC as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

All payments are due at the time of service. We accept Cash, Check, Visa, MasterCard, Discover and American Express. We accept assignment of insurance benefits from your insurance carrier. However, it is the patient's responsibility to ensure that the insurance carrier meets their obligations. The contract is between you and your insurance carrier. We are not a party to that contract. If your insurance has not paid the bill within 45 days, you will be asked to make a payment on the account to stay in good standing. We encourage you to contact your insurance company for any discrepancies. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Ada County, Idaho. You further understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible of those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Unless appointments are canceled at least 24 hours in advance, we reserve the right to charge for missed appointments with a $25.00 cancellation fee. There is a fee (currently $20.00) for any checks returned to us by the bank.

We reserve the right to charge a monthly late fee in the amount of $5.00 for accounts past 60 days. If no payment has been made in the last 60 days from any date of service, the late fee may be applied to your account.

If you are interested in payment arrangements, a consultation can be arranged. Please contact the front desk.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. I have read the financial policy. I understand and agree to the terms of this agreement.

□ I have provided a copy of my insurance card (fill out portion below) **□ I am a cash patient (no insurance)**
□ This will be billed to personal injury or work comp

INSURANCE
Who is responsible for this account? _____Relationship to Patient_____
Subscribers Name_____ Birthdate_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company named above and assign directly to Idaho Chiropractic Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Idaho Chiropractic Group may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

HIPPA ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF Idaho Chiropractic Group, PLLC's Privacy Notice that has an effective date of June 16,2004. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Idaho Chiropractic Group to assure that your records are not readily available to those who do not need them.

_____
Signature of Patient, Parent, Guardian, or Personal Representative

_____
Print Name Date