

# FINANCIAL POLICY

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Back-2-Back Chiropractic, P.C.

Welcome to our office. Please familiarize yourself with the financial policy of our office by reading the following information on our office policies.

**Office Policy on Payment Responsibility:**

Health and accident insurance provide a contractual arrangement between an insurance carrier and the insured. It is solely the responsibility of the insured to verify eligibility for chiropractic health care benefits prior to being seen in our office. Possession of a medical insurance member ID card is **not** a guarantee of coverage. Therefore, we cannot accept responsibility for determining benefits in advance of your treatment or for collection of money owed on your account from your insurance company. The responsible party is obligated for payment in full of this account. In the event your insurance company does not compensate us within sixty (60) days after billing, you are required to pay us and settle with your insurance carrier directly (not applicable to workman's compensation and personal injury claims).

In the event of non-payment, the responsible party shall bear the cost of collection and/or court costs and reasonable legal fees, should this be required. **Accounts past due will be assessed a 2.0% per month service charge.**

**Cancellation Policy:**

All appointments are expected to be honored at the scheduled date and time. In the unfortunate circumstance you need to cancel a scheduled appointment, a **minimum of twenty four (24) hours notice** is required or a sufficient reason for late cancellation must be provided. Failure to provide adequate notice or reasoning will result in a **\$25.00 fee** being applied to your account. Payment of this fee will be required at or before the time of your next appointment. Cancellation fees will not be submitted to insurance companies and are the responsibility of the patient (or responsible party).

**Billing Your Insurance Carrier:**

As a courtesy to you, we will gladly submit your bills to your primary insurance carrier. **Co-payments are due and payable at the time of service.**

**Insurance Authorizations and Assignment of Benefits:**

I authorize my insurance benefits to be paid directly to Back-2-Back Chiropractic, P.C. I authorize the release of any medical information necessary to process this claim.

**I have read this form and understand and agree to all of the above applicable policies. I authorize my insurance benefits be paid to Back-2-Back Chiropractic, P.C.**

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**Patients Name**

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**Patients Signature** (parent/guardian if under 18)

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**Date**