Financial Policy Updated 4/15

It is the policy of this office that all services rendered are charged directly to you, the patient, and ultimately, you are responsible for all services including those not reimbursed by third party payors. Patient balances may not exceed $150 at any time. Balances over 90 days and returned checks may will be subject to additional collection fees and interest charges.

Assignment of Insurance: I hereby assign my rights and authorize and direct my insurance company, or any other liable insurance company, or any other concerned party to make payment directly to W Chiropractic Incorporated. If W Chiropractic receives payment from my health benefit provider in the form of a check that is made payable to me I transfer the right to W Chiropractic to endorse and deposit the check to use towards the services rendered.

W Chiropractic Incorporated makes no representation as to whether or not the chiropractor participates in or accepts assignment for the patient's specific insurance or payor plan.

This assignment and direct payment authorization shall include any payments for services billed by W Chiropractic Incorporated in connection with services rendered.

By providing a cell phone number and e-mail address, you are allowing W Chiropractic Inc. to contact you in the way of a phone call, text message or e-mail in conducting business resulting from services provided or products purchased. The number will not be shared with any party other than those in-house or contracted to perform duties resulting from services provided to you by this office.

Financial Agreement: I UNDERSTAND, WHETHER SIGNING AS PATIENT, OR GUARDIAN, THAT THE TERMS OF PAYMENT FOR SERVICES RENDERED ARE DUE IN FULL WITHIN 30 DAYS OF SERVICE. BALANCES REMAINING AFTER INSURANCE HAS PAID ARE DUE WITHIN 30 DAYS OF THE INSURANCE PAYMENT UNLESS OTHER FINANCIAL ARRANGEMENTS ARE MADE.

I also understand that I am responsible for all charges incurred regardless of insurance or third party liability. I will pay all services in full until W Chiropractic Incorporated "qualifies" my coverage to determine the extent of benefits under my policy. I will pay the account in accordance with the regular rates and terms of W Chiropractic Incorporated. I agree that I may be responsible for 100% payment of the account.

All accounts that do not have financial arrangements will bear interest of 10% on the unpaid balance if not paid in full within 90 days.

I understand that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 50% and the additional costs and charges listed above represent the actual costs incurred by W Chiropractic Incorporated to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

If a commitment was made to a Care Plan, you will receive a discount if paid in full. If terminated prematurely, you will forfeit your prepaid discount as well as any other accumulated discounts during your Care Plan.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

The undersigned certifies that he/she has read the foregoing, has received a copy thereof, and is the patient, or is guardian to the patient to execute the above and accept its terms.

Signature_____ Date Signed_____

Printed Name_____

Witness_____