

FINANCIAL POLICY

It is our policy to assist our patients in every way to make necessary health care affordable. We want to make payment of our fees as convenient as possible and avoid any embarrassment due to misunderstanding. Please read the following information and sign this form.

Group Health Insurance

FIRST VISIT CHARGES ARE DUE AT THE TIME SERVICES ARE RENDERED. If you are covered by a Group Health Policy, either personal or through your employer, we will call your insurance company to verify your coverage and policy limits. We will also verify your deductible, if any, and unpaid deductible balance. You will be expected to pay any deductible not previously met. In addition, you will be responsible for paying the difference between what your insurance company allows and the charges for each visit. **YOU WILL BE EXPECTED TO PAY THIS AMOUNT AT THE TIME OF YOUR VISIT.** You will further be asked to sign your insurance forms at the time of the first visit and to assign your insurance benefit to this office. If you do not wish to comply with our office policy, you will be expected to pay the charges **IN FULL** on each visit, and will be given the necessary information to bill your insurance company and be reimbursed directly. You are responsible for any and all charges incurred for your care and treatment. If any charges are not allowed by your insurance company, you are still responsible for the payment of these charges, unless this office has a price reduction agreement with your insurance company.

Workers Compensation

If you were injured on the job, your charges may be paid by Workers Compensation Insurance. We will call the workers compensation company to verify if a claim has been made. In the event your claim for workers compensation is denied, you will be responsible for payment of all charges not previously paid. However, your group health insurance coverage may handle your bill as stated under the Group Health Insurance information.

Personal Injury

We will accept personal injury cases. If you have group health insurance or medical payment under your automobile policy, we will bill your insurance company for payment. Your insurance company may be reimbursed from the insurance company of the responsible party. Under no circumstance will we provide treatment to personal injury cases without payment.

Private Pay

If you have no insurance coverage, you will be expected to pay for your charges **IN FULL** on each visit.

Financial Agreement

I also understand that any costs that are accumulated in collecting an unpaid balance, such as collection agency, attorney fees or court costs, will be my responsibility. It is further understood that any outstanding balance after 90 days will be subject to a 1½ % per month finance charge.

Assignment, Authorization and Policy Statement

I hereby assign to Mira Mesa Chiropractic the benefits that I am eligible to receive for services rendered. You are hereby instructed to pay Mira Mesa Chiropractic directly for all professional services rendered to me by this office. I authorize Mira Mesa Chiropractic to release any information to any insurance company, adjustor or attorney that will assist in the payment of my claim. I further authorize my insurance company to make all checks payable to Mira Mesa Chiropractic. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original. I understand that I am personally responsible for and agree to pay any and all charges for services rendered.

Cancellation & No-Show Policy

If you have scheduled an appointment for chiropractic or massage and need to cancel or reschedule for any reason, we ask that you give us 24-hours notice. Any cancellation or rescheduled appointment that is received in less than 24-hours will be charged a \$160 cancellation fee for a new patient appointment and \$40 for follow-ups.

If you arrive more than 10 minutes late this constitutes a no show or late cancel, and you will be responsible for the fees.

Three (3) no-shows for follow up appointments in a 3-month period will result in termination of treatment. We will provide you with appropriate referrals at that time.

Two (2) no-shows as a New Patient in any given time period will make you ineligible for treatment in our office. We will provide you with appropriate referrals at that time.

Tricare & TriWest Clients Please Note:

Your insurance company does not provide reimbursement for cancelled sessions. Thus, you will be responsible for the fees.

All patients are required to have **Credit Card Payment Authorization** on file with current credit card information.

Date Patient/Insured Signature Witness Signature

Print Name: _____