

DAY CHIROPRACTIC CLINIC, P.S.

2721 E Sprague Ave Spokane, WA 99202
Phone (509) 535-3038 Fax (509) 535-9749

John W. Day, D.C. Timothy J. Day, D.C. Stephen F. Renner, D.C. Wayne M. Fichter Jr, D.C.

Financial Agreement Policy

I agree that in return for the services provided by the doctors at Day Chiropractic Clinic, P.S. I will pay my account at the time services are rendered or I will make financial arrangements satisfactory to Day Chiropractic Clinic, P.S. for payment. If my insurance company or health plan designates co-payments, co-insurance and/or deductibles, I agree to pay them to Day Chiropractic Clinic, P.S. All service balances are due and payable at the time of service. If payment is not received, we reserve the right to refuse future appointments on delinquent accounts.

No Insurance Coverage: Payment is expected on the day that services are rendered. A twenty percent (20%) fee reduction will be applied to services only if paid in full at the time of service and if your account is at a zero balance. We accept cash, check, or credit card.

Insurance: Insurance is a contract between you and your insurance company. You will need to pay your co-insurance and/or co-payments at the time of service. If you choose to pay for all of your treatment in full at time of service, we will promptly issue a refund or credit your account for future care for any credit balance. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the **final determination** of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by them. It is the responsibility of the patient to verify with your insurance company if the provider(s) you are seeing are contracted with the insurance. **If your insurance company requires a referral and/or pre-authorization, it is your responsibility to obtain and provide it to our office.** Failure to obtain the referral and/or pre-authorization may result in a denial from the insurance company, and the balance will be your responsibility.

Medicare: We are a participating provider with Medicare Part B. We agree to bill and accept contractual adjustments from Medicare. There may be services and supplies rendered in our office that are not covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) be signed by the patient/Guarantor. By signing the ABN, it is understood that you are financially responsible for payment of any services and/or supplies that are not deemed medically necessary by Medicare.

Monthly Statement: If there is a personal patient balance on the account, we will send you a monthly statement. Patients are responsible for all charges resulting from treatment provided at Day Chiropractic Clinic, P.S. Payment is due within 30 days of receipt of this statement, unless other financial arrangements have been made with the account manager.

Past Due Accounts: I understand and agree that if my account is delinquent past 90 days without financial arrangement with the office, I may be turned over to the collection agency used by Day Chiropractic Clinic, P.S.

Returned Checks: There is a fee of \$35.00 on any checks returned by the bank due to non-sufficient funds or otherwise.

After Hours Policy: If there is a 'chiropractic emergency' after office hours, there is a \$20.00 fee that is payable at the time of service. This fee is not billed or paid by your insurance company if applicable. This fee is in addition to and separate from any chiropractic adjustment fees, co-payments, co-insurance or deductible that you may owe.

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.

Patient/Legal Guardian Signature

Date

Print Patient Name