## The Chiropractic Health & Wellness Center of Dayton, Inc. (revised 04/17/2022)

# Patient Financial Policy

Welcome! Thank you for choosing our practice to serve your health care needs! We are committed to providing you and your family with the highest quality of care! We believe communication with our patients is particularly important and we encourage you to ask questions and to get involved in your treatment decisions.

**THIS FINANCIAL POLICY IS WITH YOU, AND NOT WITH YOUR INSURANCE COMPANY, therefore we cannot guarantee insurance payments**. Every policy and deductible are different. Therefore, it is your responsibility for payment of services. As a courtesy, our staff will submit insurance claims and provide you with all the necessary information to process your claims. We will work with your insurance company and will do everything possible for you to obtain your maximum benefits. After 90 days of claim submissions, we will no longer submit aged claims to your insurance and any balance outstanding is your responsibility.
I _____ (name) acknowledge that I am 100% responsible for any outstanding balances and am responsible for following up on outstanding balances _____ (signature).

Please bring your insurance card to every visit to make sure your information is current.

Please let us know if there are any policy changes or if you have moved.

**ALL MISSED APPOINTMENTS WILL BE ASSESSED A $50 FEE** _____ (initial).

## PRIMARY CARE PHYSICIAN REFERRALS

Policies that require you to have a Primary Care Physician may also require you to have a written referral / authorization to be seen in this office as a patient. If so, it is your responsibility to provide us this referral / authorization. This is a requirement of your insurance company. Your insurance company may not pay for your services without this referral / authorization. Failure to provide a referral / authorization will make you solely responsible for your bill.
I understand that I am responsible for all charges if I fail to provide a referral _____ (initial).

## MEDICARE PATIENTS

Medicare, Medigap and the majority of Medicare Supplement Plans DO NOT COVER EXAMINATIONS, EXTREMITY ADJUSTMENTS, AND ALL PHYSICAL THERAPIES.
I acknowledge that I am 100% responsible for these charges and that payment is due in full, at time of service _____ (signature).

- ☒ **We accept cash, check or credit card.**
- ☒ **All copayments are expected at time of service.**
- ☒ **For patients without insurance - payment is expected at time of service in full**
- ☒ **All Medicare payments are expected at time of service**

**I HAVE READ THE ABOVE AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES PROVIDED BY THE CHIROPRACTIC HEALTH & WELLNESS CENTER OF DAYTON, INC.**

**Signature:**_____ **Date:**_____

**Name & Signature of Person Financially Responsible (if patient is a minor)** _____