WESTON CHIROPRACTIC

OUR FINANCIAL POLICY

Dear Patient,

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Cash Patients - payment for services is due at the time services are rendered.

Insured Patients - co-pays, deductibles, and/or 20% of charges are due at the time services are rendered.

We accept cash, checks, Mastercard or Visa for your convenience.

If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed things up.

Returned checks will be subject to a $20.00 fee.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In case of special needs you can make arrangements with our office manager for payment on your account. Delinquent accounts over 60 days will be subject to collection procedures. In the event your account is turned over for collection you will be responsible for all reasonable collection and court costs up to 50% of the outstanding balance at the time the account is considered delinquent.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patients Signature _____ **Date** ____/____/____

Assignment of Benefits

I hereby guarantee payment of all charges incurred at the office of Weston Chiropractic. I hereby assign and direct to pay any and all benefits for medical services under this claim directly to Weston Chiropractic. I hereby authorize the release of any medical information requested by the insurance companies with the above assignment.

Patient's Signature _____ **Date** ____/____/____