PAYMENT POLICY

There are two forms of payment:

Cash- every time you come in. After 60 days of non-payment, a $25.00 late fee will be added to your account to be compounded monthly.

OR

Insurance Assignment- Co-pay, insurance reimbursement signed over to our clinic (As explained below)

PLEASE CHECK HOW YOU WISH TO PAY: CASH___ CHECK___ CREDIT CARD ____

INSURANCE ASSIGNMENT PROGRAM

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and a supportive health care program is recommended. We will notify you of the change.

2. All deductible amounts must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility. This must be paid at least weekly. Prepayments may also be made.

3. The insurance carriers are billed on specific 15-30 day cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed.

4. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the clinic. Failure to do this may result in collection action.

5. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.

6. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/ her own. The insurance company has 30 days from billing date to make this decision. Patient payment is expected on any fees over 30 days.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions as specified above.

_____ ___/____/_____

Patient's Signature Date