Carter Chiropractic

Financial Policy Information

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

1. You are ultimately responsible for payment of charges you receive from our office. Any check payment dishonored by your bank will result in a **$35.00 return check charge** being added to your account
2. It is your responsibility to provide us with your current address, telephone number, and insurance information.
3. It is your responsibility to contact your insurance to confirm that our physicians participate in your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.
4. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by the doctor.
5. All co-payments and deductibles are required at time of service.
6. All medical records request must be in writing and received in our office 72 hours prior to the date needed, and all medical records request will have a fee based on the number of pages. The range of fees for this service is from $10.00-$50.00.
7. Attention: Medicare Part B patients: Coverage for chiropractic care is limited. It does not pay for all services**. It will only pay for your chiropractic adjustments**. Therefore, examinations, re-examination, hot packs and EMS therapy in our office are not covered under Medicare's guidelines and are expected to be paid in full by you at the time of service.

I have read and understand the payment policy of Carter Chiropractic. I understand that my insurance is an arrangement between my insurance company and myself and that I am ultimately responsible for payment of all charges. I also understand that if my insurance does not respond within 60 days I am responsible for payment. We must emphasize that as chiropractic providers, our relationship is with you personally, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account

Please sign your name below indicating that you have read the above and understand it.

_____ _____

Patient Name (Please Print) Patient Signature

_____ _____

Date Signed Witness