Office Policy

Patient Name: _____

I understand that it is my responsibility to know my insurance policy with regard to physician participation, required referral and covered services by my insurance company.

I am fully aware that it is my responsibility to provide your office with a written referral from my primary care physician if my plan requires one. If I do not present a referral at the time of my office visit, I am responsible for all charges incurred.

I understand also that confirmation of coverage, as well as an authorized referral, does not guarantee payment from my insurance company and that I will be responsible for any charges not covered by my insurance plan.

I agree to pay any co-pays and/or deductibles as per my insurance plan and that if I receive a bill from your office I am required to pay it within a thirty day period. If there is a problem with the charges I will notify your office promptly within thirty days.

I hereby authorize Elite Chiropractic/Therapeutic Rehabilitation to furnish information concerning my illness and treatment to my insurance company, attorney, school or other treating physician. I also hereby assign Elite Chiropractic/Therapeutic Rehabilitation payments for medical service rendered to myself. I understand that I am responsible for any amount not covered by insurance and that Elite Chiropractic/Therapeutic Rehabilitation requires payment at the time of treatment unless prior Arrangements have been agreed upon.

I am fully aware that Therapeutic Rehabilitation/Acupuncture is out of network. Your insurance company may send the checks directly to you. It is your responsibility to sign the back of the check and turn it over to our office. Please include all of the paperwork included with the check. There will be a $75 fee for all missed/no show appointments not canceled within 24 hours. (Massage, Cupping, Physical Therapy, Acupuncture). **If you choose to pay by credit card there is a 3.5 % convenience fee added to the total.**

_____ _____

Signature of responsible party Date

Patient Liability Agreement

I understand that I am financially responsible for all bills incurred while under the care of Elite Chiropractic/Therapeutic Rehabilitation. In the event that my account is not paid in full, I shall be liable for any and all costs of collection. This includes, but not limited to a 35% fee of outstanding balance if my account is forwarded to a collection agency for collection and/or court action. If my account is forwarded to an attorney for legal proceedings, I agree to be liable for any additional attorney fee making a total collection and attorney fee of 50% of the outstanding balance

I further understand that there shall be a 1.5% interest charge per month on any outstanding balance that is forwarded to collection.

By signing below, I hereby indicate that I have read and understand the terms of this contact:

_____ I understand there will be a 35% fee of outstanding balance if my account is forwarded to a
Initial collection agency for collection and/or court action.

_____ I understand there will be a 50% combined collection and attorney fee if my account is forwarded Initial to an attorney for legal proceedings and/or court action.

_____ I understand there will be a 1.5% interest per month on any outstanding balance that is forwarded
Initial to a collection agency and/or court action.

_____ _____

Signature of responsible party Date