OFFICE FINANCIAL POLICY
for
Reynolds Chiropractic

Our goal is to provide and maintain a good physician-patient relationship.
Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

For Patients with Private or no Insurance:

Full Payment is required at the time of service (*see note below). We accept cash, checks, Visa, Discover and MasterCard.

1. **Charges paid at time of service** will be discounted **15% of scheduled fees** although we do round to the nearest whole dollar amount. **Unpaid charges billed by invoice will be subject to full scheduled fees.**

For Patients with Insurance:

1. On arrival, please present your current insurance card at first visit. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT CORRECT INSURANCE INFORMATION AND A COPY OF YOUR CARD.
2. On your receipt of an updated insurance card, please present that card before next visit so to avoid incorrect billing and thus full payment for service.
3. While the filing of insurance claims is a courtesy that we extend to our patients, not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
4. As a courtesy our office also verifies insurance policies for you but does not guarantee accuracy of information given over phone. Full knowledge of coverage of services on plan is not revealed until first payment from insurance company is received.
5. According to your insurance plan, you are responsible for any and all **co-payments**, **deductibles**, and **coinsurances**. These payments are **due at time of service** after receipt of first explanation of benefits.
6. It is your responsibility to understand your benefit plan.
7. It is of upmost importance to maintain treatment plan as designated by your practitioner so to insure that payment for treatments is not denied. Treatment payments may be denied and will be your responsibility if reason is for non-compliance. Note that special considerations will be correctly notated in your records by your practitioner and taken into account by insurance company if and when hardships arrive.
8. Please consult with us if you participate with a high-deductible health plan. We may require a copy of the health savings account debit/credit card or a personal credit card remain on file. There are addenda to this financial policy, which are signed separately if needed.

In-Network Policies: (means we are a contracted participating provider for your insurance company)
IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY all services performed in our office

will be submitted to your insurance as a courtesy. All co-payments are due at time of service. Deductibles and coinsurance are your responsibility and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse.

Out-of-Network Policies**:** (means we are not a contracted participating provider for your insurance company)

If we are not able to bill your insurance and we cannot accept payment from them for the services performed, we will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement. Not all services provided by this office are covered benefits in all contracts. Payment for services is due at the time of service.

For patients with **HMO plans**, co-payment is required at the time of service. The amount of co-payment varies with different plans. You are responsible for knowing the **co-payment** amount. For patients with **PPO plan**, payment is required at the time of service until the new year's deductible has been met. After that, we require co-payments or your liability to be paid at the time of service.

For All Patients:

1. For unpaid balances, we will not be adding additional charges to your bill. We appreciate your honor in this situation. But we **must forward any balance remaining over 90 days to a collection agency**. This will be regretted and may end in dismissal from the practice.
2. A **$10** fee will be charged for any checks returned for insufficient funds, **plus any bank fees incurred** and your account will be placed on a "cash-only basis".

* We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

1. I have received a copy of this financial policy.
2. I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____

_____ _____

Responsible party member's name Relationship

_____ _____

Responsible party member's signature Date