BLACKMAN FAMILY CHIROPRACTIC FINANCIAL POLICY

The purpose of this form is to clarify your financial responsibilities so we can devote our efforts to helping you.

FEES

Examinations	
New Patient	$90.00
Re-Examination	$70.00
X-Rays	$60.00 - $160.00
Adjustments	$50.00
Physical Therapy:	
Electric Stim	$25.00
Ultrasound	$35.00
Traction	$30.00 - $36.00
Self Pay for Adjustments	$40.00 ($10.00 *Discount if paid at time of visit*)
Medicare	$34.22

Missed Appt. w/o Notice $20.00

FORMS OF PAYMENT

Patients are responsible for co-payment at the time of service. We accept cash, personal check, Visa, and MasterCard. There will be a $25 service charge on all returned checks.

Co-payment not received on day of service is subject to a $10 service fee.

BILLING

Our policy is that a patient not have a personal cash balance. If special arrangements are made and a patient develops a cash balance, once over 30 days, interest charges of 1.8% or a minimum of a $1.00 per month will begin to accrue plus service fees and **any legal or collection fees**.

INSURANCE

All professional services rendered are the responsibility of the patient. We will file your insurance claims as a courtesy to you, although you, not the insurance company, are responsible for all charges incurred. We will do our best within our legal limits to support your covered services, however **your health insurance is an agreement between you and your insurance carrier**, therefore it is your responsibility to handle any disputes with your insurance company that is beyond our capability. **Payment from your insurance company is not guaranteed; you will be responsible for any unpaid charges.**

AUTHORIZATION AND AGREEMENT

I understand that my chiropractic insurance carrier may pay less than the actual billed services.
I agree that my balance is to be **paid in full** in order to receive any records or x-rays.
I agree that any and all coupons are considered null and void if patient does not return for 2nd visit within two weeks.

I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me and also authorize the release of such information as is needed to process insurance claims by provider or agent. I agree to be responsible for payment of all services rendered on my behalf or my dependents. **I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account.** I hereby order all parties to accept a copy of this release and assignment in lieu of the original.

I have read, understood, agreed to, and received a copy of this form.

Patient / Responsible Party _____ Date _____