David W. Mayer Chiropractic, Inc.

FINANCIAL PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that the payment of your bill is considered a part of your treatment. The following are statements of our financial policies.

- Payment for today's visit and your future visits is due at the time of treatment.
- We are NON PARTICIPATING in all insurance networks. However, we will call to receive a *summary* of your **OUT OF NETWORK** benefits *AS A COURTESY*. You are responsible for your entire bill. Our office will be happy to provide you with a statement that you will be able to submit to your insurance carrier for reimbursement.
- If financial arrangements have been made for extended payments, each month you will receive a statement for services, which is due and payable within 20 days of receipt. If your payment is late, or if you have not previously made financial arrangements, then we will mail a reminder notice indicating that payment is due. If you are experiencing a set of circumstances out of your control, please call our billing representative and she will be happy to make special arrangements.
- If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately.
- We reserve the right to charge a late fee of $10.00 for all delinquent accounts over 30 days past due.
- If credit is to be extended, our office may obtain a credit report.
- This office will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to deal directly with your insurance company, adjustor, or agent. Before any radiology testing or lab work is performed, it is the patient's responsibility to check with their insurance company for a laboratory or facility that is covered under their insurance plan.

Please indicate below the form of payment you wish to choose to settle your account:

[ ] Cash or Check [ ] Discover, Visa or Master Card [ ] American Express

[ ] CareCredit – *If you choose this option, please ask for a CareCredit application.*

Thank you for understanding our financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date_____
Signature of Patient or Responsible Party

X_____ Date_____
Signature of Co-Responsible Party