

Seaman Chiropractic Center

SEAMAN CHIROPRACTIC FINANCIAL POLICY

Thank you for choosing us as your chiropractic physician. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE.
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, OR DISCOVER.
WE OFFER A CHIROPRACTIC CREDIT CARD WITH PRIOR CREDIT APPROVAL.

REGARDING INSURANCE

We may accept assignment of insurance benefits after your insurance has been verified. However, we do require payment (Co-pay and any charges not covered by your insurance policy) to be paid at time of service. The balance is YOUR responsibility, whether your insurance company pays or not. All insurance carriers make clear that verification of coverage does not guarantee payment of benefits. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, the balance will automatically be transferred to you.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. We reserve the right, at our discretion, to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments, and/or by calling 24 hours in advance so another patient may be fit in.

PAYMENTS

Unless another arrangement is agreed, all co-pays and deductible are due at the time of treatment. All payments are due within 30 days of the monthly billing date. A service charge of 1.5% per month will be applied on any balance over 90 days. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other insurance. If payment has not been received, the patient is in default and is responsible for collection, filing, court or attorney fees incurred in attempting to collect this amount or any future outstanding account balances.

Thank you for understanding for Financial Policy. Please let us know if you have questions or concerns.

I have the Financial Policy. I understand and agree to this Financial Policy

X _____
Signature of Patient/Guardian

Date: _____