MADEIRA CHIROPRACTIC AND REHABILITATION

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Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and most insurances.

- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible. We do our best to provide you with accurate information the first time. However, all coverage determinations are made by the insurance company at the time services are rendered and the claim is submitted.

- If we have a contract with your insurance, we will bill your insurance first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 4 weeks from the time the claim is received by the insurance.

- If we do not contract with your insurance, you will be expected to pay for all services rendered at the end of your visit. We offer a discount cash rate from the amount summitted to insurance.

- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient /Responsible Party _____ Date _____

Name of Patient/Responsible Party (please print) _____ Relationship to Patient _____