Discover Chiropractic Center, P.C.
Office Policies

Thank you for choosing Discover Chiropractic Center, P.C. ("Discover") as your Chiropractic Health Care provider. We are committed to providing you with the best care possible.

Any X-rays taken at this office will remain the permanent physical property of this office for a minimum of seven years. Copies of the patient's X-rays and/or records will be provided when a minimum advance notice of two working days is given. We reserve the right to charge a "copying" fee for the reproduction of the above X-rays and/or records.

If you do not have health insurance or your health insurance does not cover chiropractic services, massage, or any other service provided in this clinic, you agree to be fully responsible for payment of services rendered by Dr. Eric Lambert, DC and/or Discover Chiropractic Center, PC.

Payment will be made at time of service. We accept cash, check, Visa, MasterCard, & Discover. If we have to sent you an invoice for payment a $5 service fee will be added to the invoice.

Missed Appointments Policy:

All appointments are reserved especially for you (the patient). Therefore, please be considerate of other patients, and our office staff and **kindly give at least 24 hours notice** if you are unable to make your appointment. **We reserve the right to charge you for canceled or missed appointments.** If broken appointments become habitual, you may be dismissed from care.

Missed massage appointments will be charged full price for massage if a 24 hour notice is not given.

Initial _____

Financial Policy

Insurance & Billing:

1. As a courtesy to you, we accept most major insurance companies and we will submit claims to your insurance carrier. However, we are unable to bill your insurance unless you give us all your insurance information. This courtesy may be withdrawn if circumstances warrant it.

2. If you discontinue your care, your account is immediately due and payable in full, even if an insurance claim has been filed. (If the insurance company does send us payment, the payment will be applied to your account. When your account is paid in full, the balance will be refunded to you.)

3. We will bill your insurance at least monthly during active care at this office.

4. Our office does not guarantee that your insurance will pay for the services provided. We will attempt at the beginning of your healthcare to receive verification of your policy and what services it covers.

5. Our office will not enter a dispute with your insurance company over your claim. This is your responsibility and obligation.

Important

Most insurance plans **do not cover 100%** of the cost of your treatment. We will estimate as closely as possible your appropriate co-pay and any/all deductibles, based on the information provided by your insurance company. **We require all co-pay amounts to be paid at or before the time of service. We accept cash, check, Visa, MasterCard, & Discover.** Our office will file your insurance claims. However, we will wait a maximum of 60 days for the insurance check. (Insurance is typically paid within 45 days.) We will assist you in dealing with your insurance claims. However, if payment is not received by the 61st day, you are responsible for the remaining balance. **If your account becomes delinquent, it will be subject to finance charges. The unpaid balance after 30 days of invoice will be subject to simple interest at the rate of 7% per year, until balance is paid in full. In addition, delinquent accounts will be charged a rebilling fee of $15 per month. If we choose not to charge the interest or rebilling fee for one or more months, that does not prevent us from charging them in any other month.** An account that is not paid within 90 days of invoice is generally turned over to collections or small claims court, but we may do so earlier or later in our discretion.

Initial _____ and Continue on to back of page

Authorization and Assignment

In consideration of undertaking your care, you agree to the following:

1. You authorize Discover to release any information it deems appropriate concerning your physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. You authorize the direct payment to Discover any sum you now or hereafter owe to Discover, by your attorney, out of the proceeds of any settlement of your case, and/or any insurance company obligated to make payment to you or Discover based in whole or in part upon the charges made for Discover' services.

3. If any insurance company that is obligated by contract to make payment to Discover or to you for the charges made for Discover's services refuses to make such payment upon demand, you hereby assign and transfer to Discover the cause of action that exists in your favor against any such company (the correct name(s) of which you have provided to Discover) and authorize Discover to prosecute said action in your name as Discover sees fit. You also authorize Discover to compromise, settle or otherwise resolve said claim as Discover sees fit. Until a reasonable effort has been made to collect the sums due from the insurance company or companies, Discover will refrain from collecting the amounts owed directly from you. You understand that whatever amounts Discover does not collect from insurance proceeds, whether it be all or part of what is due, you owe those amounts and agree to pay them to Discover on demand.

4. You further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed to Discover are paid in full.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns. A photocopy of the signed document will be as valid and binding as the signed original.

PLEASE READ AND SIGN THE STATEMENT BELOW

I have read, understand and accept the terms of this office policy, financial policy, & Authorization/Assignment concerning my treatment at Discover Chiropractic Center, PC. I authorize Discover Chiropractic Center, P.C. to bill my insurance company for all services rendered. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. And I understand I am responsible for any account balance.

X_____ _____

Signature of Responsible Party (Must be 18 years old) Date

X_____

Printed name of Responsible Party

X_____ _____

Staff Signature Date

(If the responsible party is not the same person as the patient, they must sign. If the patient is a minor, the parent or legal guardian must sign.)