**FINANCIAL POLICY and AGREEMENT**

We share in the concern of our patients about the increasing cost of medical care. Our fees are comparable to the usual and customary charges made by like practitioners in the area. These charges are based on their cost and the time and skill involved.

1. **Unless prior arrangement is made, full payment is due at the time of service.** For patients paying at time of service, a 20% discount will be applied to services provided.
2. I understand if this is a worker’s compensation claim, Milaka Stringham, D.C. will attempt to collect from the insurance company. If the claim is denied, I will be responsible for the balance on my account. A lien and assignment of benefits has to be signed if a worker’s compensation claim exists.
3. I understand if this is a bodily injury claim, Milaka Stringham, D.C. will attempt to collect from the applicable insurance company. If, for any reason, the insurance company denies payment, your bill will immediately become due and payable unless you have signed a lien and assignment of benefits. A lien and assignment of benefits has to be signed if a bodily injury insurance claim exists (either as a PIP, med pay or third party tort).
4. If you are presenting for treatment not associated with either a worker’s compensation claim, auto injury claim or any other type of claim for injury and you have a health insurance policy with chiropractic benefits, Milaka Stringham, D. C. will attempt to collect from your general insurance carrier. Dr. Stringham is a Blue Cross, Blue Shield, Regence in network provider, Healthnet provider, Providence provider. We will submit insurance forms at no charge as a courtesy to our patients.
5. In the event of no applicable insurance, I have arranged an agreement with Dr. Stringham to obtain her services at a reduced fee due to financial hardship. **I understand that Dr. Stringham has allowed this arrangement to receive care because I either do not possess health insurance coverage or do not have adequate funds to compensate her at this time.** I am aware this fee schedule is significantly lower than Dr. Stringham’s standard fee for services.
6. In the event a lien being signed, a copay amount of $50 per visit will be paid with the remaining fee per visit to be due upon settlement (in any form) with the worker’s compensation or third party insurer.
7. I also agree that should I obtain insurance coverage or my financial situation change, I will inform Dr. Stringham and make new arrangements with her in a timely fashion.
8. Inner-Balance Chiropractic has a 24-hour cancelation policy. If a scheduled appointment is missed without a 24-hour notice, a $35 fee will be charged to the patient.
9. Accounts more than 30 days overdue will be charged a $10 administrative fee. **Accounts greater than 90 days overdue will be sent to a collection agency.**

The agreed upon fee is $\_\_\_\_\_\_\_\_\_\_\_\_\_ per visit determined by [ ]  hardship [ ]  coupon

 Your insurance company reports that your copay amount is $\_\_\_\_\_\_\_\_\_\_\_\_ per visit.

AGREEMENT TO PAY:

I HAVE READ THIS FINANCIAL POLICY AND UNDERSTAND THAT, REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE, I AM RESPOSIBLE FOR FULL PAYMENTS OF MY ACCOUNT. ACCOUNTS ARE CONSIDERED DELINQUENT IF NO PAYMENT IS MADE WITHIN 90 DAYS AND WILL BE SENT TO COLLECTION. I AGREE TO PAY FOR ALL LEGAL FEES AND COSTS REASONABLY INCURRED WITH THE COLLECTION OF MY ACCOUNT. I UNDERSTAND THAT INSURANCE IS AN AGREEMENT BETWEEN MY INSURANCE COMPANY AND ME AND I AM RESPONSIBLE FOR ANY BILLS REMAINING AFTER ALL INSURANCE PAYMENTS HAVE BEEN RECEIVED.

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NAME OF PATIENT

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SIGNATURE OF RESPONSIBLE PARTY DATE