Financial Agreement

We would like to take a moment to welcome you to CONEJO VALLEY FAMILY CHIROPRACTIC and to assure you that you will be receiving the very best care available.

In order to familiarize you with the financial policies of our office, I would like to explain how your medical bills will be handled. Charges for treatment in this office are due and payable at the time the service is performed. However, if this is inconvenient for you, we will be glad to set up a payment plan to assist you while you are under care in our office. Please be advised that all outstanding balances must be paid within 90 days of service.

We wish to make it very clear that your health is the sole responsibility of you the patient. These policies apply only to the services actually performed and in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinued care.

I have elected to use the following payment plan to finance my care:

_____ **CASH**: I agree to pay the entire balance owing on a daily/weekly basis. I agree to pay any outstanding balance immediately after termination of my care. I further agree to pay a late fee of one and one half percent per month (1½%) for any balance that is over thirty days past due.

_____ **INSURANCE**: Although I am totally responsible for charges I may incur in this office, I will initially pay for my yearly deductible and percentage agreed upon at the time to each visit unless my insurance fails to pay at its share, at which time I will pay my balance in full.

_____ **PERSONAL INJURY**: I agree to allow CONEJO VALLEY FAMILY CHIROPRACTIC to submit all charges incurred for this accident or incident to my automobile or medical payment policy. I further agree that if no coverage is available or if I exhaust my benefits, that I will be personally responsible to pay charges incurred on a daily, weekly, or monthly basis.

_____ **WORKER'S COMP**: I understand that I am being treated for a work related condition. Furthermore, I understand that "making a knowingly false or fraudulent claim for the purpose of obtaining benefits or payments is a felony". The insurance carrier for your employer, by law, is fully responsible for payment of your care. If your care is found to not be work related you will become fully responsible for payment.

_____ **MEDICARE**: I understand that my Medicare insurance policy covers 80% of the allowed charge for chiropractic manipulation only. I agree to be responsible for all charges which are not covered by Medicare, including my yearly deductible and the 20% co-payment amount for covered services, as the time those services are preformed.

I UNDERSTAND, AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ALL FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

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Patient's Signature Date

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Print Patient's Name