# *NEW* REHABILITATION SERVICES

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## FINANCIAL POLICY

**I. GENERAL FINANCIAL POLICY**

**A.** It is our policy to collect charges for services as they are rendered

**B.** All supplements are sold on a cash basis only.

**II. INSURANCE COVERAGE – YOU ARE RESPONSIBLE FOR YOUR BILL**

Our contract is with you, not the insurance company.

**A. A WRITTEN REFERRAL FROM YOUR PHYSCIAN, CHIROPRACTOR, DENTIST IS NEEDED TO FILE FOR INSURANCE.**

**B**. The patient must complete and sign the appropriate financial agreement prior to treatment.

**C.** Provided, the annual deductible has been met, our office will extend credit for the insurance portion of your bill. Patients are expected to pay a minimum of 20% of the daily charges toward their portion of their account.

**III. MEDICARE DOES NOT COVER MYOFACIAL TREATMENT.**
**WE DO NOT ACCEPT ASSIGNMENT.**

**IV. EXCEPTIONS**

**A. WORKER'S COMPENSATION**

1. The patient must report injury to employer prior to treatment, bring all Worker's Compensation forms from the employer signed, and if Applicable a written referral form from a physician, chiropractor, or Dentist.
2. Patient must complete Worker's Compensation/Injury questionnaire.

**B. AUTO ACCIDENT**

1. Patient must complete Auto Accident/Injury questionnaire.
2. Patient must provide the name, address, and phone number of all attorney's and insurance companies so that we may bill this directly. Also we will need the claim number for this incident and a letter of protection from your attorney if one has been retained.

**C. LIABILITY**

1. The patient must provide the name, address, and phone number of all attorney's and insurance companies so that we may bill this directly. Also we will need the claim number for this incident and a letter of protection from your attorney if one has been retained.

## V. BILLINGS

**A.** Billings for any unpaid charges are sent out on a monthly basis.

**B.** On accounts 90 days/3 months or older, a ***finance charge of 3%*** will be added to the patients balance if no payment is received during the previous billing cycles.

**C.** Payment arrangements may be made upon approval by phone or in person. Final Approval will be in the form of a written contract of payment, which will be considered binding.

**D.** Accepted methods of payment are as follows:

1. Cash
2. Checks, for the amount of service only
3. Master Card or Visa

## VI. COLLECTIONS—THIS IS A LAST RESORT MEASURE

**A**. Accounts reaching 90 days/3 months with no personal payment will be placed in Collections.

**B.** Charges for collections and/or court costs will be added to the balance of the account.

**C.** If you have arranged payment with our office and this is not carried out or followed through as you have agreed to, your account will be placed in collections or small claims court, pending the balance of the account.

## VII. NO—SHOW, RESCHEDULING, or CANCELLATION OF APPOINTMENTS

**A.** You must give a 24 hour notice of cancellation or rescheduling of an appointment.

**B.** Failure to give notice of either missed, cancellation or no-show of an appointment will result in the charge for the full amount of your treatment. You the patient are responsible for this; your insurance company will not cover an appointment you have failed to abide by.

**C.** Please understand that we have reserved this time for you; it not fair to others that might possibly need this time for treatment.

**I HAVE READ THE ABOVE AND UNDERSTAND THAT THIS ACCOUNT IS MY RESPONSIBLITY**

PATIENT/GUARDIAN
SIGNATURE_____ DATE_____
PRINT_____

**PAYMENT AGEEMENT (CIRCLE ONE)**

**Pay in full; date of treatment.**

**Make weekly payments in the amount of _____.**

**Make monthly payments in the amount of_____.**