

<b><i>FINANCIAL POLICIES</i></b>
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### **Payment Required at Time of Service**

Payment is required at the time of service. This policy applies to applicable and estimated co-insurance and co-payments under your health insurance policy. If you do not have health insurance, we require full payment at the time of service and/or as per agreed payment plan.

### **Your Medical Insurance**

Our office participates with many medical insurance plans. Because each plan is different, we may not have all the details of your insurance benefits at the time of service. Specific questions about your benefits are best answered by a representative of your insurance company.

When you come for a visit, please bring with you a current insurance ID card. If we don't have current insurance information, we will consider you a self-pay patient. After we have accurate information on your insurance coverage, we will file a claim with your insurance company. In some cases, your insurance company may not cover the medical services that we provide, or may determine that some services are not medically necessary. If either of these two cases arises, you are financially responsible for these services.

If we are a participating provider with your insurance plan, both co-payments and estimated co-insurance are due at the time of service. If we are not a participating provider, you are responsible for paying the out-of-network rates at the time of service and/or as per agreed payment plan.

### **Workers Compensation**

If your condition is related to employment and you have filled a Workers Compensation claim, please let us know. We require that your employee or the Workers Compensation insurance carrier initiate or authorize a request for your appointment.

### **Automobile Accidents**

If you have been injured in an automobile accident and/or have any pending legal action, we require that you or your attorney pay for services personally or through your health or auto insurance.

### **Patients under the age of 18 – Minors**

An adult patient or legal guardian is responsible for the payment of the patients account regardless of who holds the insurance policy.

### **Refunds**

Refunds will be provided and paid within 90 days of the written termination request from the patient or from the date in which this office terminates this agreement. The refund amount will be based upon this agreement fee less the total number of individual services performed calculated at this office's normal fee schedule for these services. If the services performed are equal to or greater than the agreement fee then there will be no refund or moneys owed either to our office or to the patient.

### **Collection Agency**



I. In consideration of the services to be rendered to me, I hereby individually obligate myself to pay the account of Integrative Chiropractic in accordance with the regular rates and terms of Integrative Chiropractic.

II. I hereby authorize my insurance carrier(s) to pay directly to:

Integrative Chiropractic  
4089 Davis Drive  
Morrisville, NC 27560

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services, I hereby IRREVOCABLY ASSIGN to Integrative Chiropractic any rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source of any service and/or charges provided by Integrative Chiropractic.

III. I understand that as a courtesy, Integrative Chiropractic will file my primary insurance. If after sixty (60) days from the date of service insurance has not paid, the total balance will be considered due and payable. If payment arrangements are not made and the account is more than ninety (90) days delinquent, the account may be turned over to a collections agency. Should the account be referred to an attorney or licensed collections agency for collections, I shall pay reasonable attorney's fees and collections expenses.

IV. It is agreed that payment to Integrative Chiropractic pursuant of this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this agreement.

V. I understand Integrative Chiropractic shall have the right at any time to refuse to provide medical care of treatment to me. I certify that I am a patient or am dully authorized by the patient as the patient's general agent to execute this document and accept its terms.

***I UNDERSTAND AND AGREE TO THE ABOVE AUTHORIZATION AND AGREEMENT.***

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date