FINANCIAL POLICY

Insurance Coverage

Welcome to Lemont Chiropractic Center. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or deductible. For example: if you have a deductible of $500, and your insurance pays 80%, you are responsible for 20% of all charges incurred after you have paid your $500 deductible. Our center will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determination.

Payments

In order to help you determine your responsibility toward payment services, please read the following, and initial your preference for method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A_____As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered,

B_____I will join ChiroHealth USA for $49.00 per year which allows the doctor to discount his services rendered to me. I agree to pay for services on the day they are provided.

C_____I have insurance but I wish to file my claims personally, and agree to assume all responsibility by paying for services on the day they are rendered.

Health Insurance: (please initial)

D_____I would like Lemont Chiropractic Center to bill my insurance. I understand I am responsible for all costs of treatments.

Missed Appointments

It is the policy of Lemont Chiropractic Center to assess a $40.00 missed appointment fee to patients who cancel appointments with less than 24 hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This office provides care for many individuals. Missed visits result in time lost that could have been used to provide care for others.

_____My initials here indicate that I understand the above missed visit policy

I UNDERSTAND THAT ALL HEALTH SERVICES RENEDERED AND CHARGED TO ME ARE MY PERSONAL FINANCIAL RESPONSIBILITY. I UNDERSTAND AND AGREE TO THIS POLICY.

_____	_____	_____
PRINT NAME	**SIGNATURE**	**DATE**