Almaden Chiropractic & Wellness
Insurance Financial Policy

Financial Information:

In order to prevent misunderstandings about your insurance and our billing procedure, we would like you to know that all professional services are charged directly to YOU, and therefore, you are personally responsible for payment. If your insurance coverage runs out prior to the completion of your care, ask about our cash Financial Agreement.

ACW Will:

- Do our best to verify your specific coverage (over the phone) and inform you of the details. Please be advised that THIS DOES NOT GUARANTEE our eligibility or the terms of your coverage. This REMAINS YOUR RESPONSIBILITY, regardless of your coverage.
- **Bill your primary insurance** for you twice monthly, provided we have the necessary information.
- Retain any credit balance of your account for future care unless otherwise requested by you.
- Wait for insurance payment for 60 days, at which time we will bill you for the entire balance
- **We accept cash, checks, credit and ATM**

Your Responsibility:

- Provide us with necessary insurance (copy of insurance card) and fill out appropriate paperwork. It is our recommendation that you call your insurance yourself to verify your chiropractic coverage.
- Pay in full any part of your deductible not previously met.
- **Keep your account current** by paying whatever percentage or co-payment not covered by your insurance AT EACH VISIT or at the beginning of each week.
- Pay at the time of service for all non-covered services (supplies, massage therapy, laser therapy, soft tissue manipulation, VISITS NOT AUTHORIZED) at regular fees.
- In the event you discontinue your program of care, you are responsible for payment in full of any outstanding balance within 45 days of your last visit or your account is referred to collections.
- MISSED APPOINTMENTS without notification will be billed to the PATIENT

******I have read and commit to the guidelines of this policy.**
******I authorize the release of any medical information necessary to process insurance claims to any insurance company, adjuster or attorney to facilitate collection.**
******I agree that Almaden Chiropractic & Wellness will be given power of attorney to pay directly to Almaden Chiropractic & Wellness such sums as may be due and owing or services rendered to me. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.**
******I understand that I remain personally responsible for the total amounts due to the office for their services. A copy of this authorization will be considered as valid as the original.**

Date:_____

Signature:_____

Witness:_____