



PAYMENT POLICY

(For Worker's Comp claims and Personal Injury)

We are committed to providing you with the best possible care. If you have medical insurance, we are here to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

IMPORTANT! Payments for services are due at the time services are rendered. It is important that you verify your insurance coverage for chiropractic services. We will file your insurance for you for the first 90 days. If no payment has been made by the insurance company in that time, the balance will become your responsibility.

Your insurance is a contract between you, your employer, and the insurance company. We are not a part of that contract. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

It is your responsibility to inform us at Dynamic Chiropractic Clinic, LLC if you have changes in address, phone number, employment or insurance companies.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

Payment Policy Terms and Conditions

- 1. I authorize Dynamic Chiropractic Clinic, LLC, to release to my insurance company any records necessary to secure payment of my account.**
- 2. If I am unable to keep a scheduled visit I understand I must call 8 hours prior to the scheduled time to cancel or reschedule. I understand I may be charged a \$75 fee if I do not cancel my appointment within this timeframe. If, after I do not show or do not call to cancel for three appointments I understand that Dynamic Chiropractic will no longer schedule future appointments with me and the case will be closed.**
- 3. I agree to pay for insurance notes being dictated for the purposes of claim processing at the cost charged to Dynamic Chiropractic Clinic, LLC.**
- 4. I understand that if my account balance remains unpaid after 30 days a penalty of 18% interest (or 1.5% per month) will be applied to the balance until it is paid in full.**
- 5. In addition, I understand that if my account becomes more than three months past due that I will be charged a monthly administrative fee of \$25.**

I acknowledge and verify that I have read, understand, and will abide by this payment policy.

Patient (or Guardian) Signature

Date

Printed Name