**VOLK CHIROPRACTIC**

**PATIENT FINANCIAL RESPONSIBILITY AGREEMENT**

Thank you for allowing Volk Chiropractic to assist you. In the interest of good healthcare practices, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your recovery as stress-free as possible.

As a courtesy to you, we will bill your insurance. If there are any changes with your insurance, please let us know immediately so we can submit your claim properly. We cannot accept responsibility for collecting on an insurance claim after 60 days or for managing a disputed claim. Insurance reimbursement is a contract between you, your employer and your insurance carrier. You are responsible for any charges or portion of charges that your insurance does not pay.

Co-Pays are due at the time of service. If your deductible has not been satisfied, payment is due at the time of service. You will begin receiving month statements with any balances after your insurance company has been billed. The balance of your account is due within thirty (30) days.

I, the undersigned:

( ) have insurance coverage, and authorize direct payment from my insurance carrier to Volk

Chiropractic.

Note: **You are responsible for knowing your coverage benefits**. Volk Chiropractic will make every effort to inform you if a supply or service is not covered by your insurance.

( ) do not have insurance coverage and understand that I am responsible for payment of all charges.

I have read this credit policy and understand that regardless of my insurance coverage or lack thereof, I am responsible for payment of my account, IF IT BECOMES NECESSARY FOR A THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COST AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. This will ensure our responsible patients will not be penalized to cover costs by those who do not pay on time.

PRINT PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN(if patient is under 18 years of age)

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Payment plans are available by request, based on your current financial situation.