DARBOY FAMILY CHIROPRACTIC HEALTH INSURANCE FINANCIAL POLICY 14

It must be clearly understood that health insurance contracts are between you and your insurance company. You are responsible for understanding your chiropractic insurance coverage and for paying any amount owed per insurance remittances. In accepting your insurance on assignment, our office is basically extending you credit. This courtesy may be withdrawn at any time if warranted.

1) I understand that co-pays are due at the time of service.

2) I understand that I am financially responsible for what my insurance company states is my responsibility, (i.e. Coinsurance, Co-Pay, Deductible, Denied and/or non-covered services). I understand that I am not responsible for paying any amount that Darboy Family Chiropractic has agreed to write-off per their agreement with my insurance company as reflected on my insurance companies explanation of benefits.

3) I understand that the Federal Healthcare Information Portability & Accountability Act, (HIPPA), has restricted Darboy Family Chiropractic's ability to verify patient information. Therefore, I understand that it is my responsibility to understand my health insurance coverage. I further understand that although Darboy Family Chiropractic will attempt to verify my insurance, Darboy Family Chiropractic is not responsible to know my insurance chiropractic coverage.

4) I understand that if money is owed, I will receive a monthly itemized statement reflecting my financial responsibility. I agree to pay the balance in full within 30 days from the date of the statement unless financial arrangements have been made in writing. If I fail to pay the monthly balance in full, I agree to pay a 1.5% monthly finance charge which will be based on my month ending balance and will accrue at the end of each month until the balance is paid in full.

5) I understand that I have the right to dispute any billing. I understand that errors can occur and it is my responsibility to bring it to the office manager's attention if I feel that an error has been made.

6) I understand that I will be charged a $35.00 for each returned check for any reason.

I understand that if I fail to honor this agreement and it becomes necessary for Darboy Family Chiropractic, S.C. or its agents to employ legal and/or a debt collector to collect any amount due under this agreement, I agree to be responsible for all collection fee's, including attorney and/or debt collector fees, court fee's, filing fee's, and any other collection related fee's accrued to my account.

By signing below, I acknowledge that I have completely read and understand this agreement in its entirety and agree to the conditions within this agreement.

_____	___/___/___	_____	___/___/___
Patient Signature	Date	Staff Signature	Date
_____	___/___/___	_____	
Parent or Guardian	Date	Relationship to Patient	