DARBOY FAMILY CHIROPRACTIC HEALTH INSURANCE FINANCIAL POLICY

It must be clearly understood that health insurance contracts are between you, the patient, and your insurance company. You are ultimately responsible for any amount not paid by your insurance company. In accepting your insurance on assignment, our office is basically extending you credit. This courtesy may be withdrawn at any time if warranted.

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

I understand that I am financially responsible for only what my insurance company states is my responsibility. 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.

I understand that the Federal Healthcare Information Portability & Accountability Act, (HIPPA), has restricted Darboy Family Chiropractic's ability to verify patient information. Although Darboy Family Chiropractic will make an effort to verbally verify my benefits and will review my benefits with me per my insurance company, I understand that Darboy Family Chiropractic is not responsible for any inaccurate information that they may receive from my insurance company and that it is ultimately my responsibility to know and understand my chiropractic benefits.

I understand that I will receive an monthly itemized statement reflecting my financial responsibility. I agree to pay the balance due in full within ten 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.

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.

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 debt collector fees, court fee's, filing fee's and any other fee's that accrue to my account in an effort to collect what is owed.

By signing below, I acknowledge that I have <u>completely read and understand</u> 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	