



Financial Policy

1. Group or Private Health Insurance:

Hoffer Chiropractic P.C. and/or rendering provider will file insurance claims as a courtesy. ***All co-pays and deductibles are to be paid in full at the time of service.*** Any services not covered by the patient’s insurance or denied claims are the responsibility of the patient. Any discrepancies in insurance benefits are the responsibility of the patient. For most insurance companies, Chiropractic Care is considered a “specialty”, therefore co-pays or deductibles may be higher. It is the patient’s responsibility to know their personal benefits.

2. Medicare:

We ***accept assignment*** from Medicare. Medicare covers 80% of Spinal Manipulation once the deductible has been met. ***All other services, exams, x-rays and any rehab or therapy services, are not covered by Medicare.*** The patient is personally responsible for all non-covered services and the remaining 20%.

3. Patients Without Insurance:

Payment is due at the time of service. Hoffer Chiropractic P.C. and/or rendering provider accepts cash, checks, Mastercard and Visa. Cash plans are available to make the investment in your health more financially reasonable.

Billing:

You agree and authorize direct payment to our office on all insurance benefits as a result of the claim Hoffer Chiropractic P.C. and/or rendering provider has submitted on your behalf. Regardless of your insurance coverage as listed above, ***you are personally responsible for payment of your account.*** Returned checks are subject to a \$20 fee. In the event of default, you will be responsible to pay collections costs and reasonable fees as may be required to obtain collection of the account.

In order to control the cost of billing, Hoffer Chiropractic P.C. and/or rendering provider requires payment of all co-pays and co-insurance at the time of service. In the event you are unable to pay the balance in full, please advise us prior to the time of service. Please be advised Hoffer Chiropractic P.C. and/or provider is not a credit grantor, therefore failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collections.

_____ (initial)

Cancellation Policy:

We request 24-hour notice if you are unable to keep your scheduled appointment. We do understand that unexpected commitments may arise which do not allow the 24-hour notice. In these instances, we ask that you let us know as soon as possible so we can fill that appointment time. We do not, as a policy, charge for a missed appointment. However, if you miss reoccurring appointments, Hoffer Chiropractic P.C. and/or provider reserves the right to charge you \$25 for each missed appointment.

Consent to Treat:

I hereby consent and authorize chiropractic treatment, x-rays and physical therapy as deemed necessary by the doctor at Hoffer Chiropractic P.C.

If a minor child is being treated, the undersigned hereby consents and authorizes the doctor at Hoffer Chiropractic P.C. to administer such treatment deemed necessary on the patient.

Minors Name: _____

Patient Agreement:

I, _____, have read, understand and agree to the terms of this Financial Policy.

Signature: _____
Patient/Responsible Party

Date

Witnessed by: _____
Office Representative

Date