FONKE CHIROPRACTIC
AND DECOMPRESSION CENTER

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is a statement from our financial policy which we require you to read and sign before any medical services are rendered.

1. FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS WE HAVE A CONTRACT WITH YOUR INSURANCE COMPANY.

2. WE ACCEPT CASH, CHECKS, VISA, DISCOVER, AND MASTERCARD.

Regarding Insurance:

We may or may not accept the assignment of your insurance benefits. If the assignment is taken, you still will be responsible for any deductibles or copayments at the time services are rendered. Your insurance policy is a contract between you and your company; we are not a party to that contract unless we also have a contract with your company. If your insurance company has not paid your claim within 45 days, you will automatically be responsible for the balance.
Please be aware that some, and perhaps all, of the services provided may be deemed non-covered services or not medically necessary under Medicare and/or other medical insurance programs.
Regarding insurance plans where we are a participating provider, all copayments and deductibles are due at the time services are rendered. If your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraphs.

Usual and Customary Rates:

Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The only exception to this policy is a plan where we are a contracted participating provider.

Minor Patients:

The adult parent or legal guardian accompanying the minor is responsible for payment of the minor patient's account regardless of who the insurance policyholder is. For unaccompanied minors, non-emergency treatment will be denied unless the minor is prepared to pay when services are rendered.

THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE ABOVE FINANCIAL POLICY.
I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY:

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Signature of Patient (If Patient is under 18, a Parent or Guardian must sign.) **Today's Date**