Financial Policy - Modern Chiropractic Chicago

Thank you for choosing Modern Chiropractic Chicago. We are committed to finding a successful treatment plan to fit your needs. The following is a statement of our financial policy and must be signed prior to any treatment being rendered. By signing this statement, you understand and agree to the following:

General: I understand that (regardless of insurance status) I am responsible for the balance due on my account. I am responsible for any and all professional services rendered. This includes, but is not limited to exams, treatments, supplements, or supplies.

Missed or Late Appointments: 24-hour notice is required to cancel appointments. $50 for doctor visit or massage, $100 for initial visit or new chief complaint if cancelled less than 24 hours in advance. If you are more than 20 minutes late for an appointment without notice, that appointment may be forfeited and you may be charged a missed appointment fee. Please help us deliver the best service by keeping your scheduled appointments.

Insurance: Insurance companies may reimburse the full amount, partial amounts, or nothing at all relative to care rendered in the office. We are contracted with many insurance companies and are usually considered in network; however, this may vary with some out of state-based policies from time to time even if we participate with their IL affiliate. It is your responsibility to ensure that services are covered within your policy. We can check for you but it is ultimately your responsibility and miscommunications do not absolve you from responsibility of payment. We will file insurance claims for you, except massage therapy, but this office cannot accept responsibility for collecting insurance claims for you or negotiating settlement for you on a disputed claim. Your coverage is a contract between you and your insurance company. With your signature below, you give us permission to bill your insurance company on your behalf and understand that financial responsibility is ultimately yours.

Payment options are available. Please ask if you are unable to pay for treatment in full on the day of service as other payment options are available. You agree that in the event that you default and do not make payments in accordance with the terms indicated above, your signature below certifies that you will be responsible for all costs of collection including any and all attorney fees.

I have read the above and understand I am ultimately responsible for all charges. I authorize my insurance benefits to be paid directly to Bradley Backhaus DC LLC. I further authorize the Doctor and insurance company to release any information required to process my claim(s). Our office will assist you in working with your insurance company, but we cannot be responsible for delays or lack of cooperation/compliance by your insurance company(s) or managed care plan(s). In cases of divorced parents, the parent financially responsible for the child will be deemed responsible for payment and must make arrangements prior to services being rendered. Unpaid balances over 90 days old will be charged to the following credit or debit card. (A card must be left on file without exception or ALL payment is due at the time of service)

Type of Card__________________ Credit Card #____

Expiration__________________ CUV#____________ Zip Code________________

I have read and understand the financial policy of Bradley Backhaus DC LLC, Chicago. By my signature below I agree to the terms as set forth and further give permission for financial actions as stated with no termination date for said permission.

Print Name_______________________________ Signature_____________________________ Date______________