GFC's FINANCIAL POLICY
Please READ

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Our Financial Policy, or your financial responsibility.

- All Patients must complete our "New Patient Intake" **BEFORE** seeing the doctor.
- **FULL PAYMENT IS DUE AT TIME OF SERVICE,** unless other arrangements have been made with the doctor. We accept CASH, CHECKS, and all major CREDIT CARDS or DEBT CARDS.

ADULT PATIENTS: Adult patients are responsible for full payment at time of service. We will accept co-payments from patients that have insurance only if we are covered providers. There is a $25 charge for returned checks. Additionally, there is a $25 missed appointment fee for all missed appointments without a 24 hour notice. Please speak with the doctor in regards to special circumstances, emergencies, etc.

MINOR PATIENTS: The adult accompanying a minor, and his/her parent(s) or legal guardian(s), are responsible for full payment at time of service. This document also serves as consent to treat a minor.

SUPPLEMENTS OR SUPPPORTS: All supplements and supports must be paid for at time you receive them.

REGARDING INSURANCE: If you have insurance, we will assist you with submitting all claims billed to your insurance company. If we accept your insurance, you must pay your co-payments at time of service. Late payment charges of 1 ½% maybe added to unpaid accounts after 60 days from date of service.

Insurance is a contract between you and your insurance company. We file insurance as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as necessary. As contract providers, we may accept less than the billed amount due to "contractual allowances."

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

WORKER'S COMPENSATION: If you are covered by Worker's Compensation, or any other government-sponsored program, please discuss your payment situation with our office staff prior to date of service.

MEDICARE COMPENSATION: If you are covered by Medicare, you are responsible for your deductible and co-pays. If a supplemental insurance is provided, we will gladly submit to your insurance company for re-imbursement. You, the patient, are responsible for payment of all services provided that are not covered by Medicare and/or your supplemental insurance. You will be notified in advance regarding all non-covered services.

PERSONAL INJURY PATIENTS: Please notify the office staff if you have med-pay on your auto insurance. All patients with a personal injury claim are required to pay a minimum amount of $15 per visit (to be discussed with the Doctor). Personal health insurance may only be used if no medical coverage exists on the vehicle's insurance policy. If accepted, the patient is responsible for any co-payments at the time of service. If you have neither of the above, a minimum of $25.00 per visit must be paid. We will only carry a third party claim (with legal representation) if you have an attorney that will issue a letter of protection. If you have a third party claim without legal representation, our office will determine whether we can accept your case. If accepted the patient must fill out a Patient Lien and will have a minimum co-payment of $25 per visit.

PAYMENT ARRANGEMENTS: If you need to establish a payment plan with our office, please discuss it with the Doctor. If a mutually satisfactory agreement is reached, a payment plan will be established.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. If you would like a copy of this policy for your records, please ask for one.

I understand and agree to the financial policy as written and I authorize the release of any medical information necessary to process my insurance claim.

_____ _____

Signature Date

ASSIGNMENT OF BENEFITS:

You (the payor) are instructed to pay directly to Gonstead Family Chiropractic for all professional services rendered to me by that office. This instructing you (the payor) that this is an assignment of my rights under medical coverage for this bill. Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance.

_____ _____

Signature Date

PRIVACY PRACTICES ACKNOWLEDGMENT

Gonstead Family Chiropractic
80-150 State Highway 111, Suite C-5
Indio, CA 92201

ACKNOWLEDGMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birth date: ____/____/_____

Signature: _____ Date: ____/____/_____

Missed Appointment Policy

Gonstead Family Chiropractic charges a $25 fee for missed appointments. This charge will be the responsibility of the patient and will not be billed to any insurance company. If the patient does give 24-hour notice of missing an appointment they will not be charged the missed appointment fee. By signing this document, the patient acknowledges being informed of the Missed Appointment Policy by Gonstead Family Chiropractic and agrees to pay any fees they may accrue for missing appointments without sufficient notice.

Thank you,

Gonstead Family Chiropractic

_____
initials