Shenandoah Valley Chiropractic, PLC

Financial Policy

Thank you for choosing us as your chiropractor. We are committed to your health. Please understand that payment of your bill is considered part of your treatment. We believe that everyone benefits from a clear financial agreement before treatment. To make your financial arrangements as easy as possible we have the following methods of payment.

PLEASE CHECK ONE PLAN:

_____Plan 1: PAYMENT UPON SERVICE: Payment in full on the date of service.

Cash / Check / Visa/MasterCard

_____Plan 2: INSURANCE: If you have an insurance plan that we are filing for you, you will be responsible for any co-pay that your insurance plan does not cover at the time of service. We will submit the claim on your behalf as a convenience to you. You, however, are primarily liable. If a balance remains on your account after the insurance company has processed your claim, this balance will be due immediately.

_____Plan 3: OTHER ARRANGEMENTS: Made in advance with _____.

INTEREST: We will bill you for any remaining balance once your insurance company has processed the claim and we have received and processed the Explanation of Benefits (EOB). All balances are the responsibility of the patient and must be cleared immediately. You will have a grace period of 25 days without interest. Balances remaining after this time could be subject to a 1.5% interest per month, up to 18% per year until payment is received. There will be a $5.00 service charge for each additional statement after the first one. There will be a $25.00 fee assessed on all returned checks.

DEFAULT: In the event that my account is submitted for collection, I agree to pay all costs of collection including, but not limited to, attorney's fees, collection agency fee, interest, and court costs. I waive the benefit of all homestead or other exemptions in the collection of my account.

MISSED APPOINTMENTS: We require notice to reschedule or cancel an appointment. There may be a $10.00 fee assessed for any missed appointments, "no show" or cancellation without notice.

I CERTIFY THAT I HAVE READ THE INFORMATION CONTAINED IN THIS FINANCIAL FORM AND AGREE TO THE TERMS LISTED.

_____

PRINT NAME (NAME OF GUARDIAN IF PATIENT IS MINOR)

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SIGNATURE DATE