FINANCIAL POLICY

This is an agreement between McCarty Chiropractic Wellness Center and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we," "us," and "our" refer to McCarty Chiropractic Wellness Center.

Assignment of Insurance Benefits: You authorize your insurance company(s) to pay benefits directly to McCarty Chiropractic Wellness Center.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time if payments are not being made at each date of service.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in effect. You may receive a copy of this agreement upon request.

Insurance: Insurance is a contract between you and your insurance company. As a courtesy to you, we will verify your chiropractic benefits and file claims to your insurance company. Verification of your insurance is not a guarantee of benefits. Your insurance company will make the final determination of your eligibility and subsequent payments. If you disagree with any verification or payment on your behalf, it will be your responsibility to pay your account balance in full. Any discrepancies will be handled between you and your insurance company. Any unpaid insurance balance over 120 days will be transferred to you and it will become your responsibility.

MonthlyStatements: If you have a balance on your account, you will receive a monthly statement, it will show previous balances, new charges and any payments or credits applied to your account during the previous month. Any unpaid balance more than 90 days old will incur a non-refundable billing fee of $15.00 and be subject to collections.

Payments: A payment is due to your account on the date of service unless other written arrangements have been approved. If there is a balance on your monthly statement, payment is due within 30 days unless other written arrangements have been approved. If no payment is made after 60 days or more, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs that are incurred.

Returned Checks: There will be a $30.00 fee assessed for all returned checks.

I have read and understand the financial policy and agree to all terms and conditions stated herein. I agree to make payments on my account on each date of service. I also understand that if no payment is made on my account after 90 days, my account will be subject to be sent to a collection agency and agree to pay all costs incurred if such an event should happen.

Patient's Name: _____

Responsible Party (if not the patient): _____

Signature: _____Date: _____