Financial Agreement

Please print this form and bring it to the office on your first visit.

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition.

EXPLANATION OF INSURANCE COVERAGE

Many insurance policies cover chiropractic care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductibles and percentage of coverage and co-pays for chiropractic care. I understand that Valley Chiropractic or its Doctors do not have access to the details of my insurance plan and it is my responsibility to understand and familiarize myself with all aspects of my health benefits. In some cases, preventative care is not covered but “sick” or “acute” care is. I understand the physician can not change the diagnosis or billing codes in order for your health insurance to cover your care. If your insurance company does not deem your care “medically necessary” or we were unable to obtain an authorization from your insurance company for the care you received, you agree that you will be responsible for any unpaid balances no matter what the insurance company dictates.
I further understand that I will have to pay any deductibles and / or co-pays as well as any unpaid balances directly to Valley Chiropractic.

ASSIGNMENT OF BENEFITS

If you have health insurance that might cover your care, we will need you to sign the attached assignment of benefits. This form instructs the insurance company to send their payment directly to this office. If your insurance company sends you payment for services incurred in this office, you shall send or bring the full payment to our office immediately.

RELEASE OF INFORMATION

If your insurance company requires medical reports to document your treatment progress, your signature below authorized the release of medical information necessary to process your claim.

VOLUNTARY TERMINATION OF CARE

It is the policy of this office that if you should choose to suspend or terminate your treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

PAYMENT ARRANGEMENT

We require that you pay your balance and co-pay at the time services are rendered. All outstanding balances are due within 30 days of the statement date. Monthly statements are mailed the first week of every month. If we do not receive payment and have not been able to contact you, we then reserve the right to send your account to collections and assess you a $25 collection fee. If you write this office a check on an account that has been closed or has non-sufficient funds, you will be assessed a $25 fee.

By signing below, I acknowledge that Valley Chiropractic / Dr. Helle Leap, D.C. will provide healthcare services to me and I agree to bear full financial responsibility for all services provided.
I acknowledge that if my attorney's office or I bill the insurance company for any of the provided services, I will still be responsible for the full amount billed, even if the insurance company allows less than the billed amount.

We hope that this has answered any questions you might have regarding your financial arrangements. Once again, we welcome you to our office. If, at any time, you have any questions regarding your care, please don't hesitate to ask.

I have read and agree to the above.

Name

Signature

Date