Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of you bill is considered to be part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients who do not pay in full at the time of service must complete our information and insurance form before services are rendered.

Payment Policy
We accept Cash, Checks, Visa, MasterCard, and Discover
We charge a $30 fee for returned checks

Regarding Insurance
Full payment of estimated deductible and co-payments are expected at the time of service. We may accept assignment of insurance benefits for your visit. However, we do require that any unmet deductible and/or co-payments be paid at the time of service. The balance is your responsibility, whether your insurance company pays or not. We will bill your insurance company when you give us the required insurance information. Your contract is between you and your Insurance Carrier. Although, we will assist you with your claim by a courtesy filing you should contact your insurance regarding payment of a claim. Therefore, if your insurance company has not paid your account in full within forty-five (45) days, we require that you remit the full balance due yourself. Should your insurance pay less than you expected, or not at all, it is you responsibility to confer with your carrier should you wish to dispute your claim. However, you are still obligated to remit your balance immediately.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Liability Cases
In the event you are relying on court settlement to cover your medical expenses, our practice requires complete attorney and claim information, as well as a lien with payment at time of service of one hundred dollars or 10% of the fee, whichever is greater. We also require information regarding other health information you may have. In all cases we require that you set up payment arrangements for the period of time you case is in litigation.

Accounts Referred for Collection
In the event your account is referred to a collection agency and/or attorney, you will be responsible for any additional expense incurred by Optimal Wellness Chiropractic Center, PC in the course of obtaining payment on your account including, but not limited to, court costs, collection agency and/or attorney fees. Any such costs will be added to you unpaid debt.

Authorization
I authorize Optimal Wellness Chiropractic Center, PC and its centers to release any information required in the course of my examination of treatment. I permit a copy of this authorization to be used in place of the original and request payment of benefits to Optimal Wellness Chiropractic Center, PC. However, I do acknowledge I am responsible for payment of all services regardless of insurance coverage.

I have read the financial policy, I understand and agree to ALL the terms of this document.

____________________________________ ____________________
Patient's Signature (or Parent/Guardian if applicable) Date