



FINANCIAL POLICY

Corporate Office: 415 Cardinal Drive Elizabethtown, KY 42701
www.eriksenchiropractic.com

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

All patients must complete our information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA/MASTERCARD.

Regarding Insurance

We may accept assignment of insurance benefit after your second visit. However, we do require your deductible and co-payments be paid at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignments of benefits we require that you provide a credit card with authorization to bill that account for the balance. Please be aware that some, and perhaps all, of the services provided may be non-covered serviced and not considered reasonable and necessary under the Medicare/Medicaid Program and/or other medical insurance.

Personal Injury/Workers Compensation

This office will work with your insurance company and attorneys in order to facilitate payment of your bills. However, you are still responsible for any and all unpaid portions after settlement. If you, the patient, discontinue care for any reason prior to being released by your doctor, your bill will be due in full at that time.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a Visa/MasterCard or payment by cash or check at time of service has been verified.

Records

X-rays are a necessary diagnostic examination tool and the fee paid is for the interpretation done by the doctor. The information on the films belongs to the patient, but the actual film belongs to the office and remains the property of this office for a period of seven years.

IN THE EVENT THAT WE ARE FORCED TO SEND YOUR ACCOUNT TO COLLECTIONS YOU WILL BE RESPONSIBLE FOR ANY FEES INCURRED FOR THIS PROCESS.

I authorize any and all insurance benefits are paid directly to the physician. I authorize Eriksen Chiropractic Centers to keep my signature on file and charge my Visa/MasterCard account for the balance of charges not paid by insurance within 90 days and not exceed \$2,500.00. I understand that this form is valid for one year unless I cancel the authorization through written notice to Eriksen Chiropractic Centers. I have read the Financial Policy. I understand and agree to this Financial Policy.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

Signature of Patient or Responsible Party

____/____/____
Date

Credit Card Account Number

____/____/____
Date