

Mason Family Chiropractic Financial Policy

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize that payment be made directly to the provider at the address below for all insurance benefits which would otherwise be payable to me under my insurance or pre-paid health care plan.

Dr. Richard Mason or Mason Family Chiropractic 11580 Overlook Dr., Suite #200, Fishers, IN 46037

RELEASE OF INFORMATION:

I authorize this office to release any information concerning my health and health care services to my insurance companies or pre-paid health care plan.

PAYMENT AGREEMENT:

Patients without insurance are expected to pay the balance in full for each visit.

Patients with medical insurance are expected to pay the copay, deductible and co-insurance in full for each visit. When possible, we will call for your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. **In the event that full payment is not made for any reason, I understand that I am responsible for the entire outstanding balance.**

I understand that if my insurance company requires me to obtain a referral from my primary care physician before seeking chiropractic care that I am responsible for obtaining that prior to seeing Dr. Mason.

We will do our utmost to provide sufficient information to your insurance carrier to obtain payment for your treatment. However, in some cases insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care.

Occasionally, either by mistake, or your insurance policy plan provisions, the check issued by the insurance company is made payable to you, instead of our office. In the event that payment is made to you, you must understand that you are responsible to make the payment in full to our office immediately.

I understand that if I can not keep a scheduled appointment with Dr. Mason, I need to call the office prior to my appointment to cancel and/or reschedule. If I do not call before the appointment I will be charged a \$35 "No Show" fee.

IF I AM MORE THAN 10 MINUTES LATE, I MAY NEED TO RESCHEDULE MY APPOINTMENT _____

I have read and understand the financial policy of Mason Family Chiropractic. I understand that if my insurance company denies or does not pay a claim in full, I am responsible for the entire outstanding balance immediately. I understand that if my account is not paid in full within 90 calendar days then it will start accruing a monthly interest rate at 8% until the balance is paid in full. I understand that once my account becomes delinquent it will be turned over to a collection agency. I understand that I will be responsible for all collection costs, reasonable attorney fees, court costs and all interest accrued during the collection process.

Print Name _____

Date _____

Signature _____

Witness Signature _____

Date _____