YEAGER CHIROPRACTIC AND WELLNESS
FINANCIAL POLICY

METHOD OF PAYMENT: Payment is due at the time of service. The amount due for services will depend on whether you have insurance, are self-pay, or are going through a Third Party Administrator. See below for further information regarding insurance, self-pay and Third Party claims. The accompanying adult to a minor patient is responsible for payment. For your convenience we accept, Visa, MasterCard, cash and personal checks.

CHECK RETURN FEE: There is a $35 charge for checks returned due to insufficient funds.

LATE RESCHEDULE/CANCELLATION/NO SHOW FEE: While some cancellations and reschedules are inevitable, cancellations and reschedules with less than 24-hours notice or missed appointments (no-shows) have unfortunately become a great expense to our organization. If you call with less than 24 hours notice or if you don't call at all to change an appointment, you will be charged a fee for the time we saved for you. No shows, missed appointments or changes in appointments made with less than a 24-hour notice will be charged a **$25 fee for chiropractic treatment visits** and **$50 for chiropractic examinations, nutritional consults and new patient visits** and **$40 for massage visits**.

INSURANCE: Our services are rendered to you, not your insurance company. In most cases we will call to verify your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. We will bill your insurance plan and will collect any copay, co-insurance or deductible due by you at the time of service. Any non-covered service fees will also be collected at the time of service.
If your health plan determines a service to be **"not covered"** or is **not an eligible expense under your plan**, you will be responsible for the complete charge or remaining balance of the non-covered service(s). Payment is due upon receipt of that statement from your insurance company.
It is uncommon but pre-authorization from your insurance company may be required for chiropractic care in order to receive full benefit coverage. If you are not sure pre-authorization is required for your plan, please contact our office or your insurance company to verify your plan benefits. If required, an authorization must be received by our office prior to your visit. Failure to provide Yeager Chiropractic and Wellness Center with proper authorization may result in delay or rescheduling your appointment. You will also be financially responsible for all services related to your visit.

PERSONAL INJURY/ AUTO INJURY/WORKER'S COMP (THIRD PARTY ADMINISTRATOR): Please advise our office on your first visit whenever you have one of the above claims. We will work with insurance companies/attorneys involved, *but please remember that you are ultimately responsible for your bill if payment cannot be obtained from another party*. If you, your attorney or the insurance company does not cooperate in protecting the doctor's interest, we will not await payment but may declare the entire balance due and payable immediately.

BALANCE: All balances are due within 15 days of verbal or written notification. Accounts with outstanding balances will be turned over to a collection agency and will be subject to all collection fees, court costs and reasonable attorney fees to collect unpaid accounts.

I have read and understand the financial policy set forth by Yeager Chiropractic and Wellness Center, and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice. I understand that I am responsible for all costs of my care, regardless of insurance coverage. I understand all balances are due within 15 days. I understand if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse YEAGER CHIROPRACTIC for all costs of such collection efforts, including but not limited to all court costs, all collection fees and all attorney fees.

Patient Signature: _____ Date: _____

PRINT NAME:_____