Financial Policy:

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete our patient intake forms, supply their insurance cards and provide a picture ID before seeing the doctor.

Unless previous arrangements have been made, all payments are due at the time of the appointment. Payment may be made by cash or check. We will bill insurance carriers directly for your convenience but if a payment is made to you by the insurance company, that check must be signed over to our office for payment of service.

It is your responsibility to supply our staff with your primary and secondary insurance identification cards at the time of your appointment. If your insurance requires a copay, it must be paid at the time of the appointment.

At times your insurance carrier will deny payment for authorized services. If so, you may be asked to help resolve these issues with your insurance carrier.

As you have been advised, this office may or may not participate with your insurance plan. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

Our practice is committed to providing the highest quality of treatment to our patients and we charge what is usual and customary for our area. We know how confusing insurance plans can be. If you have any questions, please feel free to ask us. We may be able to help you.

Returned check fee - $35.00 If our bank charges us a fee for any check that is returned for "insufficient funds", this amount will be added to the returned check fee as well.

Any outstanding balance for which the patient is responsible for is due within 30 days of billing. Any account that has gone 60 days without a payment is subject to immediate collection process. Accounts that go to collection will be subject to a collection fee of $100.00 or 25% of the total balance due, whichever is greater. There is also a 1.5% interest charge per month of the outstanding balance to be calculated from the last date of service.

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns, please feel free to ask.

I have read the above financial policy for D'Agostino Chiropractic and I understand and agree to abide by its terms.

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Signature of Patient/Parent/Guardian Date