

**FINANCIAL GUIDELINES & PATIENT RESPONSIBILITY POLICIES**

At Mark Pierce Chiropractic Clinic, we take great pride in offering the very best chiropractic care and personal attention to each of our patients. We believe that everyone benefits when definitive guidelines are agreed upon. Accordingly, we have prepared this material so that you will understand our policies prior to your appointment.

- ◆ I am fully responsible for payment of any and all services incurred by me at this clinic. If I choose to use my insurance benefits, I am responsible for charges not covered or reimbursed by my insurance company.
- ◆ In the event that I receive payment from my insurance company for services rendered, I agree to pay the full amount of payment to Mark Pierce Chiropractic Clinic.
- ◆ We require a 2 hour notice for all missed appointments. This allows time for other patients to come in for care but did not have an available appointment. I am aware that there is a No Show/Cancellation fee of \$15.00 for an office visit and \$25.00 for a massage appointment that is missed by me or not canceled within 2 hours of the appointment.
- ◆ At the time we verify your insurance benefits, your insurance company informs us that the verification is not a guarantee of benefits and is based on your specific policy and guidelines. On occasion, your insurance company may deny or pay for your services at a rate other than what they actually quoted. Therefore, it is important that you know your policy guidelines and become proactive in making calls to your insurance company regarding charges, disputes, coverage, etc. Our professional services are rendered to you, not the insurance company. Deductibles and Co-Pays are payable at the time of service. Any previous balance is expected to be paid at time of service. Please let us know of any changes to your insurance coverage as soon as possible.
- ◆ I authorize my insurance carrier to assign and directly pay all insurance benefits to Mark Pierce Chiropractic Clinic. I also authorize agents of any hospital, treatment center or previous physicians to furnish the clinic with copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed.
- ◆ There is an administrative fee of \$25 for all disability, FMLA, and other forms/paperwork that you need to have filled out by the physician. Please allow 5-7 business days for paperwork to be completed.
- ◆ If applicable, Mark Pierce Chiropractic Clinic has agreed to treat me with a Letter of Protection which guarantees payment of outstanding charges that accrue after my insurance benefits have been terminated for whatever reason. These charges will be paid out of the proceeds of any pending litigation in my case. I hereby direct my attorney or responsible party who controls the disbursement of funds after my litigation has been resolved to pay Mark Pierce Chiropractic Clinic in full for any unpaid balance.

I acknowledge that I have carefully read and understand the Financial Guidelines and Patient Responsibility Policies. A duplicate of this statement is considered the same as the original.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date