

MARKET PLACE CHIROPRACTIC WELLNESS CENTER

9633 Market Place #103 Lake Stevens, WA 98258
Telephone (425) 335-0300 • Facsimile (425) 335-0302

Jeffrey P. Clark, D.C., C.C.W.P.

FINANCIAL POLICY

Our primary concern is for your health. Below are the options available to address your financial needs. Please read the following. Select the choice most appropriate for you and sign where indicated.

To all our insured patients: As a courtesy to you, we will submit your billing to your insurance carrier for you. However, your bill is always your responsibility. Insurance is an agreement between you and your insurance carrier. For our Payment Plan, Medicare and Private Health Insurance patients, all charges for supplies must be paid at the time they are received.

All account balances are due in thirty (30) days and are over due in sixty (60) days. Accounts over ninety (90) days outstanding will be acted upon for collection. Collection costs are added to your account. A late fee of one percent (1%) per month is charged on overdue accounts. All NSF checks will be issued a \$35.00 fee.

I understand and agree to the above financial policy and will abide by the terms of the PAYMENT OPTION I have initialed below.

PAYMENT OPTIONS: Initial your choice.

_____ **Self Pay / Time of Service (Discount):** Payment in full on each visit.
Additional discount for pre-payment.

_____ **Payment Plan:** I agree to pay Market Place Chiropractic Wellness Center a

minimum of \$_____ by the _____ day of each consecutive month. It is understood that I must make payments EVERY month in order to continue this plan. If I do not, the full balance will be due immediately.

Date

Signature

[Print Name]

_____ **Medicare:** Medicare covers a portion of visits per year after your deductible has been met. MEDICARE DOES NOT COVER X-RAYS, EXAMINATIONS, OR SUPPLIES. Services not covered by Medicare are due when rendered unless other arrangements have been made.

_____ **On the Job Injuries (L&I):** If you were injured on the job, we must verify your injury with your employer and file the appropriate forms. Please notify your employer so that they may file the necessary forms with your worker's compensation carrier. If the claim is disallowed or transfer of physician is not approved, industrial insurance does not cover any of the treatments you receive and the bill is YOUR responsibility to pay.

_____ **Personal Injury Cases:** We bill your insurance company on your Personal Injury Protection (PIP). Notify your insurance company or agent that you are under care at this office. A medical lien is placed on the claim to protect your medical payment benefits. Patients without PIP use the Payment Plan until time of their settlement or until the balance is paid in full, unless other arrangements are made. Payment arrangements must be made within 90 days of claim closure at Market Place Chiropractic Wellness Center. **It is your responsibility to file a PIP application with your insurance carrier within 7 days of initiating chiropractic care.** A copy of your PIP application should be provided to us as part of your permanent record.

_____ **Private Health Insurance:** You are expected to pay all co-payments (percentage and/or fixed fee) at the time of service. You are responsible for any portion of payment(s) which is/are applied to your deductible. We will submit your primary insurance for you and reimburse you for any credit balance we receive as a result of payment from your insurance carrier. It is YOUR responsibility to call and verify your chiropractic benefits with your insurance company. If your insurance plan requires a referral from your PCP, it is YOUR responsibility to acquire it. We will assist you in this process as indicated. We will provide to you per your request any necessary copies required for secondary or tertiary insurance. We will not assume any responsibility for billing secondary insurance.

My insurance coverage pays _____%

I have a \$_____ deductible.

My per visit co-payment is: \$_____.

My per visit co-insurance is: \$_____.

Limits are: _____

Your bill for services rendered is always your responsibility.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Dr. Jeffrey P. Clark, or Market Place Chiropractic Wellness Center, operating under Tax Identification Number _____ 26-2978460, for chiropractic benefits available under my insurance policy. Further, I request that all chiropractic benefits allowable under my insurance policy be issued directly to Dr. Jeffrey P. Clark. Should my contract prevent direct payment, I request that any draft issued to me be made jointly payable to Dr. Jeffrey P. Clark. I authorize Market Place Chiropractic Wellness Center to initiate a complaint to the Office of the Insurance Commissioner on my behalf, if applicable.

Signed: _____ Date: _____