Harmony Heals, Inc

Financial Agreement: We would like you to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, we would like to explain how your medical bills will be handled. All patient portions of charges for treatment in this office are due and payable at the time the service is performed. The first visit is to be paid in full at the time of service for all patients with or without insurance benefits (except workman's compensation or personal injury). **Please Initial where it applies.**

Payment Plans

_______**PRIVATE PAY:** I agree to pay for each visit at the time of service or I will agree to prepay for visits on a weekly/monthly basis. *Discounts are offered with prepaid visit plans. *

_______**PRIVATE/GROUP INSURANCE:** I understand that the terms of my insurance policy are between the insurance company and myself. Should my insurance company deny any charges incurred, I will be personally responsible for payment for those services in full. I agree to pay my yearly deductible amount and my co-insurance amount at the time of service or prepay on a weekly/monthly basis. I will pay for the first visit in full at the time of service. That payment will be applied toward my yearly deductible, co-insurance amount or will be fully refunded if my insurance pays 100%. * As a courtesy our staff will verify your health insurance benefits but we cannot guarantee payment or the accuracy of benefits quoted.*

______**MEDICARE:** I understand that my Medicare insurance policy only covers 80% of allowed charges for spinal manipulation procedures performed by a chiropractor. Any and all other charges are considered not covered by Medicare. I agree to be personally responsible for payment of my deductible amount, my co-payment amount for covered services and for all noncovered services such as: x-rays, vitamins/supplements, pillows or supports.

______**PERSONAL INJURY:** I agree to allow **Harmony Heals, Inc** to submit all charges incurred for this accident to my automobile medical payment policy. I further agree that if no medical coverage is available with my auto insurance or if I exhaust my benefits, that I will be personally responsible to pay for all charges incurred. If medical coverage is not available on my auto insurance policy my private health insurance may be billed.
ATTORNEY LIEN: I understand that **Harmony Heals, Inc** has agreed to carry the balance of any unpaid charges on a lien with my attorney. I further understand that if I change attorneys or release this attorney prior to the settlement of my claim this agreement is void and I agree to pay the full balance due immediately.
3rd PARTY CLAIM (no attorney): I understand that I am making a claim against a 3rd party insurance policy and that this policy does not reimburse the doctor directly for any services incurred as a result of my claim. I agree that I am personally responsible to pay charges incurred on a daily/weekly/monthly basis or at the time of settlement of my claim.

______**WORKMAN'S COMPENSATION:** I understand that I am filing a worker's compensation claim. I also understand that if I do not follow the doctor's recommendations for care or if I miss appointments my claim may be denied. If my claim is denied because of my failure to follow the doctor's recommendation for treatment or because I miss appointments I understand I will be responsible and liable for the balance of the bill.

______**MISSED APPOINTMENT FEE:** I understand and Agree to pay a fee of $25.00 upon a missed appointment that I did not cancelled within a 24 hr notice. I understand that this fee includes a massage appointment as well, if I did not cancel within the 24 hr period.

I further understand that if I suspend or terminate my care with this office, my balance will be immediately due and payable.

I have read and agree to the above:

_______________________________ Date:____________

Patient's Signature

To be completed by patient's representative If patient is a minor or incapacitated:

_______________________________ Date:____________

Parent or Legal Guardian's Signature