Fuhr Chiropractic Clinic
3714 E. Indian School Rd Phoenix, AZ 85018
Eric A. Petermann, D.C.

Financial Responsibility Policy

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which governs the payment terms for any treatment you receive. *We require that all patients please read, **initial highlighted area and sign** prior to any treatment.*

_____ **PATIENTS WITHOUT INSURANCE**

We offer a 25% Time of Service Discount of billable charges if balances are paid in full the day they are rendered. We are happy to accept cash, check and any credit/debit card payment. We also offer a "Prepaid Wellness Plan". Please ask to find out how to qualify.

_____ **REGARDING INSURANCE**

We do require your co-insurance and /or co-payment be paid at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable or necessary under the Medicare and/or other medical insurance guidelines. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company. You may pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees as stated above. We then can provide you with any billing you can submit to your insurance carrier for reimbursement. _____ It is to be understood and agreed that I am responsible for any and all services rendered and are charged to me directly; I am personally responsible for payment of any non-covered services, deductibles, co-insurance or co-pays. _____ I understand I am responsible to know what services are covered and any limitations of my policy prior to obtaining services. _____ It is to be understood and agreed that I am responsible for any and all allowable charges which remain after my insurance has paid its portion. _____ I consent to the use and disclosure of my protected information to carry out payment activities in connection with insurance claims. I also herby authorize any and all insurance benefits are paid directly to the physician.

_____ **DELINQUENT ACCOUNTS**

Accounts are considered delinquent if unpaid after 60 days from the date of service. IN THE EVENT THAT WE ARE FORCED TO SEND YOUR ACCOUNT TO COLLECTIONS YOU WILL BE RESPONSIBLE FOR ANY FEES INCURRED FOR THIS PROCESS.

_____I have read the Financial Policy. I understand and agree to this Financial Policy.

_____	_____	____/____/_____
Printed Name	Signature of Patient or Responsible Party	Date

_____ ____/____/_____

Witness / Fuhr Chiropractic Staff Member Date

Verification of coverage is not a guarantee of payment, actual insurance coverage or that your insurance company will make a payment. Insurance benefits are determined when your insurance company receives a claim. In the event of insurance changes or termination, you, (the patient) are responsible to provide the office with that information. Please let us know of any concerns.