FINANCIAL AGREEMENT

1. I understand that health insurances, worker's compensation, motor vehicle/personal injury and other third party payer policies are arrangements by and between insurance carriers and the subscriber. **Furthermore, I understand that it is my responsibility to be aware of the benefits available to me through my insurance carrier and that it is in my best interest to call my health insurance company and verify my individual benefits.** I understand that I am responsible for securing a **REFERRAL, PRE-AUTHORIZATION** and/or **CLAIM NUMBER** from my **HEALTH INSURANCE CARRIER, WORKER'S COMPENSATION CARRIER** and/or **MOTOR VEHICLE/PERSONAL INJURY THIRD PARTY PAYER**. If this information is not provided to **DeFalco Family Chiropractic (hereinafter DFC)** at the time of my **FIRST VISIT**, I agree that I am responsible to **pay out-of-pocket for the services rendered to me** until such time the information (referral, claim number, pre-authorization and prescription) is provided to **DFC.**
2. I authorize the release of any and all medically necessary information to process all claims related to services rendered at DFC.
3. I authorize payment of medical benefits directly to **DFC** for professional services rendered.
4. I understand that **payment** for all services rendered to me is ultimately my **individual** responsibility.
   - **Co-payments and payments toward deductibles/co-insurances** are due and payable at time of service.
   - Any and all unpaid balances for professional services are due within **30 days of discharge** from services at **DFC.** If payment is **NOT received within 30 days, all balances** are subject to an **18% finance charge annually.**
5. **DFC requires a 24 hour cancellation notice. There is a $25.00 service fee for NO-SHOWS or CANCELLATIONS without proper notice. This charge is NOT covered by your medical insurance and is billed directly to the client and will be collected at the time of the next scheduled appointment. Repeated missed appointments may warrant discontinuance of care.**

   ____________________(patient initials).
6. Your appointment may be cancelled and you may be charged for the cost of your treatment session, if you are more than 10 minutes late for your appointment.
7. There is a $35.00 returned check fee.
8. **If there are any changes to your Health Insurance Benefits or Carrier, it is your responsibility to notify and update DFC within 10 business days.**
9. **If your injury is related to a Motor Vehicle Accident, Personal Injury or a Worker's Compensation Injury, it is your responsibility to inform DFC.**
10. **It is your responsibility to inform DFC if you have secondary insurance.**

It is DeFalco Family Chiropractic responsibility to provide quality patient care, verify each patient's insurance benefits, to file insurance claims as a courtesy to the patient. A 60-day period will be extended for pending insurance payment, after which the patient may be held responsible for the entire balance.

By signing this form, I acknowledge that I have reviewed and agree to DFC's use and disclosure of my private healthcare information (HIPAA) for treatment, payment and health care operations.

I have read and agree with all the provisions within **DFC's financial agreement**. I further acknowledge that all the information given, whether oral or written by me to DeFalco Family Chiropractic is true.

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PATIENT or GUARDIAN SIGNATURE **Date**

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Signature of Authorized Clinic Representative **Date**