FINANCIAL POLICY – Auto Accident

4771 Trier Road, Fort Wayne, IN 46815 (260) 492-8300, Fax (260) 492-8301

1. It is the policy of Fort Wayne Chiropractic that all services rendered are charged directly to you, the patient. Ultimately, you are responsible for the payment of all services, including those not reimbursed by third party payers.

2. The privileges of having Fort Wayne Chiropractic submit your insurance claims begin after you have provided us with complete and accurate insurance information.

3. This office does not promise that any insurance will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

4. Our office will comply with their requests to furnish the insurance company or attorney with any medical records or reports of your conditions, as long as you sign an authorization form from the insurance company or attorney to do so.

5. If you are waiting for a settlement through your attorney or from the insurance company and you still have a balance once you are in receipt of your settlement, Fort Wayne Chiropractic expects the balance to be paid in full immediately. You will be billed immediately following our notification of settlement, and if payment is not made within 30 days, the balance will be turned over to a collection agency and a 20% interest fee will be added.

6. Once your med-pay limit on your auto insurance policy has been exhausted, you will be required to provide Fort Wayne Chiropractic with your health insurance information or you will be responsible for full payment at the time of service is rendered.

7. Should you discontinue care for any reason other than being discharged by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted. If payment is not made within 30 days, the balance will be turned over to a collection agency.

8. It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to a doctor-patient relationship that works for our mutual benefit.

I, _____, give Fort Wayne Chiropractic my permission to file my claims directly to _____. I understand that I am personally responsible for payment of services rendered to me for treatment by Gregory Hough, DC. I also authorize payment(s) to be made directly to:

Fort Wayne Chiropractic
Gregory J. Hough, DC
4771 Trier Road
Fort Wayne, IN 46815

I hereby state and agree that a photocopy will be as valid and binding as the original.

_____ Date

_____ Patient/Responsible Party Signature