

Tumwater Chiropractic Center, PLLC
128 D. Street Tumwater, WA 98501
360.570.9580

FINANCIAL POLICY

We appreciate your decision in consulting us for your chiropractic health, care needs, and we will do all that we can to provide you with the best of care. In return, we ask that you carefully review the portion(s) of this policy statement, which relate to your particular circumstance. It is our goal to provide the best care without undue financial stress.

BASIC POLICY:

The financial policy of this office is that payment is required at the time that the services are rendered. You may pay by cash, check, or debit/credit card. If other financial arrangements are needed, please speak to the office manager prior to seeing the Doctor.

PRIVATE INSURANCE:

Upon verification of our coverage, we will bill your insurance carrier directly. You will be responsible for your annual deductible, co-payment and any other portion of the bill not covered by your insurance. You must understand that your health insurance is an agreement between you and your insurance carrier. While we will help in anyway possible to secure payment from your carrier, all charges are ultimately your responsibility.

WORKER'S COMPENSATION LABOR AND INDUSTRIES:

If you are injured in an "on the job" accident, worker's compensation insurance covers the cost of chiropractic care necessary to restore you to pre-injury status or maximum medical improvement. You must report the injury to your employer immediately and complete the necessary accident form. Upon validation of your claim, all costs will be the responsibility of the insurance carrier, whom we will bill directly. **Note:** Failure to comply with the recommended treatment schedule could result in premature closure of your claim.

PERSONAL INJURY INSURANCE:

Accidents involving automobile collision, liability against a private party, etc. will be handled in this office on an individual basis. Possible options for payment include: your personal auto insurance (personal injury protection), your personal health insurance, or our basic financial policy. Your claim may require that you retain an attorney. Please inform the office manager of the circumstances involved in your case and we will determine the appropriate method of payment.

Our policy requires payment in full for all services rendered at the time of the visit unless other arrangements have been made. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account. In addition, interest in the amount of 1 % per annum may be charged to any account over 30 days.

I authorize Tumwater Chiropractic Center, PLLC to perform any necessary services needed during diagnosis and treatment. I also authorize the provider or managed care organization to release any information required to process insurance claims.

I understand the above information and acknowledge that it is my responsibility to inform this office of any changes in my medical status.

DATE

PATIENT'S NAME

PATIENT'S SIGNATURE

WITNESS NAME

WITNESS SIGNATURE