Equ.S.T. CHIROPRACTIC

Name: _____

DOB: _____

Financial Policy Acknowledgement

Payment is due at the time of service. Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a contractual discount by your company. There are NO time-of-service discounts, insurance, in-network, or out-of-network insurance agreements under the circumstances dictated in the Financial Policy.

I have read, received a copy, and understand Equ.S.T. Chiropractic, PLLC's Financial Policy. I understand that Equ.S.T. Chiropractic, PLLC does not accept any form of insurance and that I am personally responsible for submitting my own insurance claims for potential reimbursement. I also understand that I may need to meet my deductible before my insurance will reimburse me.

Initial that I read:_____I also understand that Equ.S.T. Chiropractic, PLLC does NOT treat patients over 65 years of age, on disability, Medicare, or state-funded insurance like Medicaid or Meridian, auto accidents, personal injury, or worker's compensation. I understand that I must inform the receptionist and/or doctor BEFORE treatment if I am over 65 years of age, on disability or SSDI, Medicare, or state-funded insurance like Medicaid or Meridian, was in a recent auto accident, seeking personal injury settlement, or worker's compensation.

Initial that I read:_____I understand that Equ.S.T. Chiropractic, PLLC does NOT treat patients for worker's compensation, personal injury cases, or on-going auto accident cases. I understand that I must inform the receptionist and/or doctor BEFORE treatment if my treatment involves a worker's compensation (ie, employer or company paying for care), personal injury (ie, attorney, businesses, and/or liability insurance paying for care), or an auto accident (ie, attorney, and/or auto accident insurance paying for care).

The Patient/Responsible Party authorize(s) the release or receipt of, and disclosure of all medical information related to the Patient's treatment and care, to or from any entity, which is, or may be liable, for Physicians charges, or to or from any Professional Review Organization associated therewith. The Patient/Responsible Party authorize(s) the release or receipt and disclosure of all or any part of the Patient's medical records to or from any other health care provider who may be of assistance, in the opinion of the P.C., in providing medical care and treatment for the patient, and/or assisting in any reimbursement or benefits to which patient may be entitled. A photostatic copy of these authorizations and agreement shall be as valid as the original.

By signing this document, I authorize this office to bill me directly for services, and release or receive any information necessary for my treatment.

I understand that failure to pay will result in no further treatment until previous services are paid for in full. I understand that Equ.S.T. Chiropractic, PLLC does not invoice, and all payment is due at the time of service in cash, check, credit card, or barter.

_____ _____

PATIENT SIGNATURE DATE

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PARENT SIGNATURE (if minor)

Updated 08/17/2023