ABOITE HEALTH CENTER, Inc. / LYONS CHIROPRACTIC CLINIC, P.C.

5649 Coventry Lane, Fort Wayne, IN 46804-7145 Phone: 260-436-6565

FINANCIAL POLICY

We welcome you to Aboite Health Center and assure you that we will provide the very best health care available for your condition. This policy explains how your bills will be handled. Our policy regarding payment for service is simple: Payment is due at the time service is rendered!

**GROUP/INDIVIDUAL HEALTH INSURANCE POLICY:**

Under certain circumstances, we do provide the courtesy of waiting for payment from a third party insurer. To receive this courtesy, you must provide us with a copy of your insurance card and driver’s license for use in verifying your coverage and identity. We will contact your company to verify eligibility of benefits. All information provided to us by your insurance company including any policy limitations or exclusions will be discussed with you.

If your insurance company informs us that you have a deductible; YOU MUST PAY 100% OF YOUR CHARGES UNTIL YOUR DEDUCTIBLE IS SATISFIED. Once you have met your deductible, we will accept authorization for direct payment of benefits to this office. Since most health insurance plans do not reimburse 100% you may be assessed a small co-payment. CO-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED. Indiana state law requires collection of co-pays as described in your insurance plan.

\_\_\_\_; (Patient initials confirming agreement to payment of deductible and co-payments.)

Patients selecting to assign insurance payment to us, understand, this office submits bills and awaits direct payment from insurance companies as a courtesy, and that it in no way relieves patients of their financial responsibility to this office. If your insurance company denies or delays reimbursement to this office for any reason, we reserve the right to demand immediate payment in full from you, the patient. We will not enter into a dispute with an insurance company over reimbursement; this is the patient’s obligation. MONITORING ANY POLICY LIMITATIONS IS CONSIDERED THE RESPONSIBILITY OF THE PATIENT.

\_\_\_\_; (Patient initials confirming agreement that I am responsible for payment for services.)

If you receive payment from your insurance carrier during the period which you assigned payment to the clinic, you must bring the check into this office within one week of receipt, or on your next visit, whichever is sooner, and endorse it over to this office. Failure to do this may result in immediate collection action against you. Also, there will be a $30 charge for checks returned to this office for insufficient funds or any other reason.

I have read, understand, and agree to all of the above

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_