**FINANCIAL POLICY**

**Patients not billing insurance:**

* 100% of the visit cost is to be paid in full at the time services are rendered.
* For your convenience, our office accepts cash, check, and credit card payments.

**Patients billing insurance:**

**\_\_\_\_\_\_\_ *INITIALS NEEDED*: Our office needs any and all insurance information from you prior to receiving treatment, even if you don’t believe that one of the insurance carriers will pay for services rendered. Your insurances are aware of other carriers and this affects the processing of your claims. Some carriers require referrals and prior authorizations prior to treatment in order for them to be payable. By signing this financial policy, you are agreeing to provide us with all insurance information. If you don’t provide us with required information to bill your insurance(s) (including but not limited to DMAP/OHP and Pacific Source Community Solutions, MODA and Regence), you are thereby taking responsibility for the payment of those services. If your insurance coverage changes during the time you receive care at our office and services are not paid by your insurance(s) as a result of not informing our office, you will be financially responsible for paying for the services rendered.**

* After verification of your coverage, we will accept payments directly from your insurance carrier.
* Patients are responsible for all uncovered services at the time of the visit, such as copay, co-insurance and deductible amounts.
* Patients must stay current with their patient responsibility balance.
* After all insurance claims have processed, we will reimburse you if you made an overpayment.
* Our office gives an insurance company 90 days from an incurred charge to pay their portion. If for any reason they do not pay in 90 days, then the balance becomes the patient’s responsibility and is payable at that time.
* Your insurance is an agreement between YOU and your insurance company. Therefore, this clinic does not guarantee that your insurance company will pay the charges and will not enter into a dispute with the insurance company over reimbursement. If your insurance carrier denies a payment, the patient is personally responsible for payment. Verification of coverage is not a guarantee of payment for services rendered.
* Patient must notify our office if there are any changes to their insurance coverage while receiving care at our office. Failure to do so may result in lack of payment from their Insurance(s) and will be the patient’s financial responsibility.
* The patient is responsible for any and all attorney fees for collection of past due accounts.
* Our office requires 24 hour notice when canceling an appointment. If less than 24 hour notice is provided, a $25 fee will be charged. If a patient reschedules with less than 24 hour notice or no show two times for an appointment, any appointment thereafter will need to be scheduled and rendered on the same day only.
* Our office provides appointment reminders via SMS texting/voice services and by signing this form, you consent to the fees associated by your phone carrier to process these communications. If a patient wishes to opt out of this service in the future, they need to provide written notification to our office.

I agree to the above listed terms set forth by Cascade Chiropractic & Natural Medicine.

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 **Signature Date**