

CHIRO KINETICS CHIROPRACTIC FINANCIAL POLICY

PERSONAL INJURY/AUTOMOBILE ACCIDENT

The following policy applies to patients who are being treated for injuries sustained in an automobile accident, or injuries sustained from another party involvement, (defined as "personal injury").

By signing this form, you agree to comply with all the policies listed below.

1. Chiro Kinetics does not extend credit. The patient, or the person financially responsible for the patient, hereinafter referred to as "patient", agrees that any outstanding balance is their final responsibility. Chiro Kinetics will attempt to collect payment for services rendered by billing any and all insurance companies involved in the patients' claim. This will include, but is not limited to, the patients' automobile insurance, the third party insurance company, the patients' health care insurance and any other relevant insurance company as deemed necessary. If for any reason, the insurance company denies payment, the patient agrees to pay the outstanding balance in full within 7 days of the insurance company denying the claim.
2. In the event that legal representation is acquired by the patient, and if there is no insurance coverage that will pay the outstanding bill, Chiro Kinetics agrees to allow the outstanding amount to remain owing until the case settles, or one year after date of the accident, whichever comes first. Once the case is settled, or once one year has transpired, (whichever comes first) the outstanding balance **must be paid** in full within 7 days, by the patient. Late fee charges of 1.5% per month are assessed on the account beyond that date.
3. If the case is a third party lien you have **2 weeks to have the insurance company of the party who caused the collision sign the "NOTICE OF DOCTOR'S LIEN FOR INSURANCE"** and return the form to this office. If it is not signed and returned within this time period your bill will be immediately due and payable and you will be required to pay for services at the time they are rendered. A monthly late fee of 1.5 % will be charged on any outstanding balance. At that point in time we reserve the right to discontinue your care here.
4. The patient agrees to sign an attorney lien in duplicate, an insurance lien, a Power of Attorney to endorse checks, and an assignment of benefits, and to provide any other pertinent information that will allow Chiro Kinetics the legal right to collect the amount owing from the insurance company, and/or the final settlement pay out.
5. In the event that a lawsuit or settlement attempt is lost or dropped by the patient or the attorney, the patient agrees to pay the outstanding balance in full within 7 days of the date the settlement is lost. Furthermore, the patient agrees to have on file with Chiro Kinetics a valid credit card number, and authorizes Chiro Kinetics to use the credit card number for payment if the amount owing is not paid in full at the agreed upon time. The patient also agrees to give Chiro Kinetics their social security number to have on file. Chiro Kinetics will hold this information in the strictest confidence, and will only utilize the information in the event that other collection attempts did not result in payment in full. If any outstanding amount is not paid in full within the agreed upon time frame mentioned above, Chiro Kinetics will begin assessing late fees on the outstanding amount at the rate of 1.5% per month. Any returned payments will be assessed a \$35 service fee (will increase as bank charges increase) which will be added to the outstanding bill.
6. After final resolution of the case, Chiro Kinetics may recommend further treatment to ensure that the patient remains in good health. If the patient decides on accepting further care, any amount incurred must be paid in full at the time of the visit, and the patient agrees to read and sign our office policy for a cash based treatment plan.
7. If the case is a third party lien, the patient agrees to follow the treatment plan the doctor prescribes for them during the course of the case. If the patient does not comply with said prescribed treatment plan, all monies become due and payable. The outstanding balance **must be paid** in full within 7 days, by the patient. Late fee charges of 1.5% per month are assessed on the account beyond that date.

By signing this agreement, you agree that you have read and understood the above.

Signature of the financially responsible Party

Date

Print name of the financially responsible person

Social Security number of the financially responsible person

Visa, MasterCard, Am. Express, Discover card
Number of the financially responsible person

Patient Name (if other than financially responsible person)

Expiration Date

V-Code

Witness

Date