

Financial Agreement

Dear Patient,

We have attempted to provide you with the necessary information to determine the type of care you require and also the financial information you need to determine how you wish to handle your financial obligation to **Hassig Family Chiropractic**.

We wish to make it very clear that your health is the sole responsibility of you, the patient, or guardian.

These policies apply only to the services actually performed, and in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the balance is due in full within 30 days of discontinuance of care.

I have elected to use the following payment plan to finance my care at **Hassig Family Chiropractic**.

_____ Cash – Payment is due at the time of services.

_____ Medicare – Payment is due at time of services.
Hassig Family Chiropractic will complete all necessary Medicare forms on my behalf.

_____ Worker’s Compensation – My employee has agreed to pay for the services rendered by this office. I understand that I am responsible for any portion of this bill that my employer or his insurance carriers may refuse to pay.

_____ Personal Injury – Although my insurance or lawsuit may eventually pay **Hassig Family Chiropractic** in full for services rendered, I will pay this office \$50.00 toward my initial visit, and \$25.00 per week thereafter, until my bill is paid in full, whether active or inactive as a patient.

_____ Insurance Policy Coverage – Although I am totally responsible for charges I may incur in this office, I will initially pay for my yearly deductible and the percentage or co-pay amount agreed upon at the time of each visit unless my insurance fails to pay its share, at which time I will pay my balance in full.

Note: **Hassig Family Chiropractic** will refund any overpayments made to us upon completion of care.

Patient’s Signature _____

Witness _____

Date _____