TEACHOUT CHIROPRACTIC & WELLNESS CENTER
16730 McGregor Blvd, Ste 111
Fort Myers, FL 33908
239-466-5656

FINANCIAL PAYMENT AGREEMENT:

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- We are a network provider in a DMPO that you may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
- If you are eligible & choose a pre-payment plan, auto-debit plan or "prompt payment" option.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of October 20, 2017 our office will be unable to extend any type of discounts other than those listed above.

As a courtesy to our patients, insurance claims will be filed for you. We require full payment of deductibles and co-payments at the time of service. Please remember that you are responsible for full payment of your account regardless of insurance coverage. An insurance policy is a contract strictly between the insurance company and you, the policyholder. Therefore, after the initial follow-up, any problems with the insurance company will be your responsibility. Please let us know if we can be of assistance.

I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

If you are unable to keep an appointment we require a minimum of 24 hours' notice. If we are not notified sufficiently you will be charged a $20 missed appointment fee. If you discontinue care, your bill will be due, IN FULL, within 30 days. If your account is not paid within 90 days of the date of services, and no financial arrangement has been made, your account will be sent to collections.

Accepted methods of payment are as follows: Cash, Money Order, personal check, Visa, MasterCard, America Express and Discover. If, however, your personal check is returned by your bank due to non-sufficient funds, we will charge your account $15.00, if this happens more than once we will no longer accept personal checks from you.

I have read and understand the full office policy for payment addendum as given to me. All my questions have been fully answered. I hereby authorize payments of benefits directly to the provider of benefits due to me for services rendered.

If I have been involved in a work-related injury and my employer's worker's compensation carrier denies my claim, I accept full responsibility for my care and account.

If I have been involved in an automobile accident or other personal injury and my claim is partially paid or unpaid by the insurance carrier, I accept full responsibility for my care and account.

We invite you to discuss with us any questions regarding your care and our services. The best health services are based on a friendly, mutual understanding between provider and patient.

X _____

Signature