Financial Terms and Agreement

Please read the following terms carefully and sign at the bottom to indicate your acceptance of our financial terms and policies. Thank You

Charges and Fee:
Our office understands if an illness or an emergency causes you to miss an appointment. However, we require a 24 hour advance notice of a cancellation so that another patient may be scheduled for that appointment. Failure to give at least 24 hours advance notice will result in a $20.00 charge to you.
All payments, co-pays and deductibles will be due at the time of service. The benefits quoted to us by your insurance company are listed below. In the event that your insurance company does not pay according to these benefits, you will receive a bill from Ashford Chiropractic Center which will be due within 30 days. You may then choose to appeal to your insurance company regarding their responsibility for payment. In the event of non-payment, your account will be placed in collection, and late fees will then be incurred.

Insurance:
If you have medical insurance that covers Chiropractic care, please indicate your preferred method of payment for the services that you receive in this office:
_____ I will pay in full for the services I receive from Ashford Chiropractic Center. I would like for Ashford Chiropractic Center to file my claim with my insurance and I will receive payment directly.

---OR---

_____ I choose to assign my benefits to Ashford Chiropractic Center. I understand that I will be expected to pay my ESTIMATED portion on the day services are rendered. I also understand that I am ultimately responsible for any amounts not paid by my insurance within 45 days. I have the option to appeal to my insurance directly if I disagree with their processing of my claim. My signature will be kept on file for all claims submitted on my behalf. Furthermore, I understand Ashford Chiropractic Center requires a guarantee of payment assigned in the form of a credit card as listed below.

Signature on File for Assignment of Benefits

I authorize release of any information relating to the claims Ashford Chiropractic Center will submit on my behalf for services rendered in their office.	I hereby authorize payment of my medical benefits directly to Ashford Chiropractic Center.
Signature (Patient or Guardian of Minor) Date	Signature (Insured) Date

Type of Card_____ Card #_____ Exp. Date_____

Name as it appears on card_____

Signature of cardholder authorizing payment described above_____

YOUR BENEFITS AS QUOTED TO OUR STAFF BY YOUR INSURANCE COMPANY:

Deductible_____ Met_____ Co-Pay_____ Pt. %_____ Ins. %_____

Requires: Authorization_____ Pre-Certification_____ Referral_____ None_____

Max$ or # visits/year or other limitations_____ Staff initials_____

FOR ALL PATIENTS: I understand and agree to all the terms of this Financial Agreement. I also understand the benefits stated above were quoted to Ashford Chiropractic Center by my insurance company, however Ashford Chiropractic Center is not responsible for how my insurance company actually processes my claim.

Signature of Patient/Guardian **Date**