Annual Financial Policy

Thank you for choosing Fox Chiropractic Center for your chiropractic Care. We are committed to providing you excellent care.

Group Health/Liability Insurance*

It is the patient's responsibility to provide us with current/accurate policy information when using a health insurance carrier. As a courtesy we will bill your insurance within 10 days of treatment.

* Patient copays or any out of pocket expenses, including account balances (if any) should be paid at the time of your visit.
* Our office will, nor cannot, guarantee your insurance will pay for your services. If your insurance claim is denied you will be responsible for your bill in full. It should be noted your benefits are a contract between you and your insurance company and this office only serves as an intermediary. We will at no time enter into a dispute with your insurance carrier over your claim. This is your responsibility and obligation.
* Workers compensation, personal injury, and/or managed care may take additional time to process and the charges may accrue over time. In some instances there may be limitations on your policy and if you elect to continue treatment, under these provisions you will be solely responsible for the balance.
* **Most Insurance does not cover acupuncture, massage and some services such as those. It is Your responsibility to know what is covered.**

If you have an **HMO** insurance it is your responsibility to verify with insurance and get **Referral** if needed before appointment or you will be responsible for payment.

I hereby authorize any payment of benefits made directly to Fox Chiropractic Center. Additionally, I authorize the release of any medical information necessary to process the claims.

Print Name: _____

Patient/Guardian Signature: _____

CASH PATIENT: SELF PAY:

* Payment for Cash claims must be made at the time of service. Once entered into a cash agreement Fox Chiropractic will not, under any circumstance bill any previous cash charges to another party or insurance company. Please review and understand our cash policy pricing with the front desk.

I hereby authorize Fox Chiropractic to bill me directly for any services received at their facility. I understand I am responsible for payment of those services at the time of my appointment.

Print Name: _____Date_____

Patient/Guardian Signature: _____