

ENGEL CHIROPRACTIC, INC.

26597 N. Dixie Hwy., Ste. 159
Perrysburg, OH 43551
419-874-9744

OFFICE POLICY

If you do not have insurance coverage of any kind, you will be expected to pay for services in full at each visit. We accept checks, Visa, MasterCard, Discover, American Express and cash. If you are going to be on a regular treatment plan of one or more months, it is possible that a payment plan may be worked out for you. Just ask to go over this with our Office Manager if desired.

For those patients who are covered by insurance, we will accept assignment of benefits to our office. Most policies do not cover 100% of the cost of your treatment. Because of this, and the extreme delay in receiving the payment from the insurance company, you will be asked to pay your deductible and your portion of your charges for the day or week the service is rendered. We will estimate as closely as possible your coverage, but until payment is actually received from your insurance company, it is just an estimate and may not be enough. If that is the case, you will be required to pay the allowable amount not covered by insurance. If your insurance company pays more than we estimated or if your portion, listed on the insurance explanation of benefits is less than we estimated, you will be given the option of crediting your account for future services/products, or receiving a check from us once all of your explanations of benefits from submitted claims have been received by us.

Whether you are covered by insurance or not, we offer a 10% discount for full payment made at the time of service to all patients. If you choose our discount option and you plan to use your insurance, you must then file your own claims. This discount does not apply to products or supplies.

We will assist you in dealing with your insurance company, but you are ultimately responsible for any payments due that your insurance does not cover, no matter what the reason. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account, including collection agency fees and/or attorney fees.

If you have any questions that remain unanswered before or after treatment, feel free to ask. We value you as a patient and want to do everything we can to keep you healthy.

I have read and understand the above office policy.

Patient Signature

Date

Witness

Date