Optimal Chiro – Rehab Center

8303 Arlington Blvd, Suite 202 Fairfax, VA 22031
Tel: (703)573-4773 Fax: (703)573-2552 www.oc-rc.com

[PATIENT FINANCIAL AGREEMENT]

Patient Name: _____

Responsible Party Name: _____

Relationship to Patient: _____

Payment for the patient's portion of medical services is due at the time the service is rendered. Our office is happy to verify your insurance benefits for you. Insurance estimates are provided as a courtesy, however, they are **estimates**. Our office will process your insurance claim for you, but in the event that your insurance carrier pays less than the estimated amount, then you, the patient or guarantor, are responsible for the full unpaid balance. We accept cash, checks, and credit cards for your convenience.

Our staff will do their best in going over your treatment and answer any questions relating to your insurance. Please understand:

1. Your insurance is a contract between you, your employer, and the insurance company.

2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. **It is the patient's responsibility to review and know their policy and its limitations, as it is an agreement between you (the patient) and your insurance company.**

3. Our fees are considered usual, customary and reasonable and fall within the acceptable range for most medical insurance companies and our demographic area.

We must emphasize that as health providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

• **Missed/Broken Appointment:** There is a $25 cancellation fee for time reserved for appointments missed, broken, or cancelled without 24-hours advanced notice given.

• **Checks Returned:** There is a $50 charge for check returns and non-sufficient funds per incident.

• **Finance Charge/Collection Fees:** Over 30 day balances are subject to a 1% interest rate per month, 12% per year charge on your account. You agree to pay our reasonable attorney's fees incurred in the collection of any overdue balances and consent to Fairfax County as the exclusive venue for any litigation arising out of this agreement.

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_____ I understand and agree that, regardless of my insurance status**, I am ultimately responsible for the balance of my account for all health services rendered.** In the event that an insurance company obligated by contractual agreement to make payment upon demand by you, or does not make payment within sixty (60) days from the date of your billing, I become personally responsible for payment of that amount. I will have thirty (30) days following notification by your office to clear the account by contacting my insurance company. If the account has not cleared within the allotted thirty (30) days, I hereby authorize you to charge any outstanding amount on the credit card account listed below.

_____I will promptly **bring in any insurance checks that I receive to the office. If I fail to do so within five (5) business days of receiving the checks, I authorize charges to my credit card for the amount of the checks.** I also understand agree that if **checks are lost or damaged I am personally responsible for payment**

_____I understand that I can be charged **$25.00** if I fail to provide 24-hour notice for appointment cancellations and/or frequent abuse of scheduled appointments, and charged **$50.00** for all returned checks or non-sufficient funds transactions.

_____I understand that it is my responsibility to inform this office of any **address** or **contact phone number changes** on my account.

_____I authorize this office to **release information relating to my medical care to my insurance company**. **I desire that medical insurance check payments to be sent directly to the doctor**.

_____I agree to pay our reasonable **attorney's fees incurred in the collection of any overdue balances and consent to Fairfax County as the exclusive venue for any litigation arising out of this agreement.**

_____I hereby authorize **Optimal Chiro-Rehab Center** and its agents to bill my credit card for charges incurred by me.

Print Name (as it appears on card): _____
Billing address: _____
_____

CC#: _____
Expiration date: _____ CID #: _____

I authorize and give consent for medical treatment of the person named above and agree to pay all fees and charges for such treatment and services rendered. In the case it is treatment for a minor, I agree as the parent and/or legal guardian of the minor receiving medical care at this office, I am ultimately responsible for all payments of fees for medical services rendered to the minor in my care.

Printed name: _____

Signature: _____ Date: _____