Foundation Chiropractic Clinic
1515 S. Byrne Rd, Suite 106
Toledo, OH 43614
419-389-1721

Financial Policies & Payment Agreements for Major Medical Patients

Thank you for trusting us with your health. We will do everything we can to assist you in getting and staying well. The following policies are established so that we can provide you with the best possible service.

Definition: Chiropractic is the philosophy, science and art of things natural; a system of gently adjusting the segments of the spine to remove nerve interference, restore life flow, and for the correction of the cause of disease.

Office Hours: Our office sees patients by appointment Monday, Wednesday and Friday. Emergency care is available by calling our office.

Appointment Times: Please make every effort to maintain your appointments and your schedule of care. Our staff will try to reschedule you in the same day, or the next business day to make up any missed treatment so that you can stay on your schedule of care. You must call if you are going to miss your appointment time.

Patient Education: We want you to be an informed partner in your health care. Please ask any questions that you may have. We offer free health pamphlets and use of informative videos and books. Please see our front desk clerk for more information on the availability of these materials.

Referrals: Our office is built on referrals from our patients and friends. Your referrals are always welcome. Patient's family members are encouraged to get their spines checked on a yearly basis to promote better health.

Financial Policies for Major Medical & Group Health Insurance Patients

We want you to get the care that you need in our office and will work with you so that finances are not a barrier to treatment. Our normal office visit is based on the level of service that the doctor renders.

We will bill your insurance company for you if you wish. You must supply us with all insurance information and a copy of your insurance card. It is your responsibility to obtain any referrals or prior authorization required by your insurance plan.

By signing this form you agree that you will be responsible to pay any portion of the charges that your insurance company does not pay. You also agree that if you fail to pay the outstanding balance within ninety (90) days of the due date that your obligation may be referred to a third-party collection agency or attorney. You also understand that you will be responsible for all collection fees, interest and other expenses necessary to collect on your account including court costs should legal action be taken against you or the responsible party.

If you would like to pay in full for your treatment at the time it is rendered a time of service discount will be applied and a receipt will be generated for you to send to your insurance company for reimbursement directly back to you. Please discuss your payment options with our staff.

We accept cash, checks, Visa and Mastercard.

The above information is true to the best of my knowledge and I acknowledge that I have read, understand and agree to all of the terms set forth above.

Printed Patient Name: _____

_____ _____

Signature of Patient or Patient Representative if patient is a minor — Date

The benefits below are not a guarantee of payment; they are listed for your information only based on what your insurance company has stated that they cover.

Insurance Company Name: _____ Phone: _____
Insurance Representative Quoting Benefits _____
Deductible Amount: $_____ Deductible Left: $_____ Co-pay per visit: $ _____
% Coverage: _____ Annual Max $ _____ or # of visits _____
Max per visit $_____ Therapies covered? _____ annual max # of visits? _____