HEALTH CHOICE CHIROPRACTIC CENTER, LLC
Tim E. Peristeridis, D.C.
Dean A. Bender, D.C.

611 Howard Street
Kalamazoo, MI 49008

FINANCIAL AGREEMENT

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time.

INSURANCE/THIRD PARTY/CONTRACT SERVICES
If your care is covered by a third party or contract service (i.e. group health insurance, managed care, Medicare, personal injury, auto insurance, or Workers Compensation) our office will, as a courtesy, bill that insurance. All services are rendered and charged to the patient, and NOT to an insurance provider. This means **you are ultimately responsible for all charges.** Charges not paid by the insurance company within 60 days will be transferred to the patient. Charges denied for any reason will be transferred immediately. We will not become involved in disputes with your insurance company or attorney for any reason, other than to supply factual information. The verification we receive from your insurance company will stand, unless proof is sent in writing from your insurance company or the insured's human resource department. As a courtesy, we will file your secondary insurance, but will not accept assignment. You are responsible for payment of all deductibles and co-pays at the time of service. Your secondary insurance will reimburse you if any compensation is due. **VERIFICATION OF BENEFITS BY OUR OFFICE IS NOT A GUARANTEE OF PAYMENT.** It is your responsibility to obtain any required referrals from your primary care physician and/or insurance company if a referral is required to receive chiropractic treatment.

***Be advised that some insurance companies do not cover modalities such as hot packs, manual traction, neuromuscular re-education, manual therapy, or therapeutic exercises**. These procedures are performed separately from spinal manipulations and have separate charges. If insurance denies payment for modalities, all payment will become the patient's responsibility. A listing of prices for these procedures is available at the front desk.

SPECIAL ARRANGEMENTS & SELF PAY: If you do not have insurance, payment must be made for each visit at the time of service. We have never denied anyone the benefits of chiropractic care due to their inability to pay our published fees. If financial hardship necessitates: individual consideration and special payment arrangements can be made.

FORMS OF PAYMENT
Patients are responsible for full payment, co-pays or deductibles at the time of service. Supplements and supplies are routinely not covered by insurance and must be paid for in full when obtained. We accept cash, personal checks, Visa, MasterCard, and Discover.

BILLING
Any outstanding balances are billed monthly and considered past due. In the event legal proceedings or collection actions are taken against your account you will be responsible for any fees incurred. Returned checks are subject to a $25.00 collection fee. Paying at the time of service helps reduce billing costs, which in turn helps keep our charges reasonable.

NO SHOW POLICY
We realize that unexpected circumstances can arise. However, we appreciate a 24 hour advance notice for all cancellations. It is our policy to assess your account $20.00 when an appointment is not kept or cancelled in advance.

I UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL AGREEMENT

_____ _____
Patient/Responsible Party Date

_____ _____
Front Desk Date