Heaney Family Chiropractic & Massage
Financial Agreement

Let's clarify the financial aspects of your care so we can direct all of our attention to balancing your body. Outlined below is our Financial Agreement.

Third Parties:
If you have health insurance, were injured on the job, in an automobile accident or some other personal injury, you may have other options. In general, we expect payment of deductibles, co-payments and coinsurance at the time of each visit, or at the end of the week when multiple visits per week are occurring.

- I am responsible for all co-payments, deductibles, and co-insurance as per the terms of my contract with my insurance carrier.
- **All co-payments must be paid at the time of service.**
- I am responsible for obtaining any and all required referrals for service.
- I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
- I am responsible for updating my health insurance information with the office any time the information changes terminates, or new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
- The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I agree to make payment

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY: I hereby authorize payment directly to the Provider. I understand that my insurance policy is a contract between myself and my insurance provider and that I am ultimately financially responsible for non-covered services. The Provider will file my insurance claim only as a courtesy.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Provider to release any information required to process my claim.

Individual Consideration:
If there is financial hardship associated with receiving care in our office, please understand that we have never refused any client due to their financial situation. We will however come to some agreement for payment of services that both parties can agree on.

Billing:
We have a payment at time of service policy however we understand that circumstances sometimes change. Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. Balances beyond 30 days will be charged a billing fee of 5% per month, plus any legal or collection fees. A check returned from our financial institution is subject to a returned check fee. The current fee is $25.00 per return.

Missed Appointments:
I understand that if I have an appointment and fail to cancel it at least twenty-four hours in advance, during the business hours of this office, that I will be charged a $25 fee for a missed adjustment and/or a $42.50/$60 fee for a missed massage. I understand that insurance companies do not typically pay this fee and that this responsibility is mine alone.

Agreement:
This is the entire financial agreement between Heaney Family Chiropractic & Massage and the patient below. I have read this agreement, understand it and agree with its provisions.

_____
Patient's Name Printed

_____
Patient Signature

_____
Guardian Signature if applicable

_____
Date Signed

Heaney Family Chiropractic & Massage
Patient Authorization for contact regarding chiropractic care, related health services/products, workshops & newsletters

It is the desire for our staff to use your name, address, email address and/or telephone number for the purpose of contacting you to advise you about health related meetings, referrals, workshops, newsletters, and products. The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care. Your personal information will neither be provided to, nor sold to, any other company, organization or group. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Heaney Family Chiropractic & Massage or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____
Name Date

_____
Email

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed. Your revocation request should be addressed to our office.

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