Patient Financial Agreement

Understanding our financial policies is an important part of your overall experience with our office and staff. Feel free to ask any questions you may have about this financial agreement. Please read these polices carefully and sign below, indicating that you have read and understood the details within.

Insurance, Benefits, and Coverage

As a courtesy to you, our billing service (Billing Business Specialists LLC) will submit your insurance claim(s) for treatment rendered at this office. Please be advised that your insurance policy is a contract between you and your insurance company. If you ever have any questions regarding your coverage and or benefits, please contact your insurance company. Ultimately, you are responsible for all costs incurred during treatment.

Out-of-Pocket Patients

- Patient Exam Bundle - $205.00 (X-rays/Consultation/Adjustment)
- Adjustment - $45.00
- Acupuncture - $80.00
- Spinal Decompression - $55.00
- X-Rays Only- $160.00
- 1 Hour Swedish Massage - $70.00 (1/2 Hour - $40.00) (1 ½ - $90.00)
- 1 Hour Deep Tissue Massage -$85.00 (1/2 Hour -$50.00) (1 ½ - $105.00)

Personal Injury/Auto Accident Patients

Once the patient is released from all the physicians or therapists, the full amount of charges will be due within six months. If the case is not settled with the insurance company, the patient may make payments. However, the balance in full must be paid in 90 days. If there are special circumstances in which the bill cannot be paid at that time, you may speak to the doctor and make payment arrangements.

I hereby agree to pay upfront for all services performed at Parkway Chiropractic on the date of service. If I have decided to use my insurance for the services provided, I understand that there is no guarantee that my insurance company(ies) or health plan will cover or pay for all of my charges. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Notwithstanding denial, reduction of benefits, or failure to pay for any reason, I understand that I am responsible for all services rendered to me that are not covered by insurance. I also understand that if I suspend or terminate my care, any fees for services rendered to me will immediately be due and payable. I also understand that Parkway Chiropractic will check my insurance for in-network benefits regarding chiropractic treatment. I understand that the description given is only a general outline of benefits and therefore is not a guarantee of benefits. If I have any doubts with what my insurance quoted Parkway Chiropractic, then I must check my benefits myself.

Patient Signature _____ **Date**_____