# FINANCIAL POLICY

This is an agreement between **Skye Chiropractic** and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we," "us," and "our" refer to Skye Chiropractic.

**Assignment of Insurance Benefits:** You authorize your insurance company(s) to pay benefits directly to Skye Chiropractic.

**Authorization:** I authorize Skye Chiropractic, and their respective agents and contractors to contact me regarding my balance at the current or any future phone number that I provide for my cellular phone and other wireless device using automated telephone dialing equipment or artificial or pre-recorded voice or text messages.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in effect. You may receive a copy of this agreement upon request.

**Insurance:** Insurance is a contract between you and your insurance company. As a courtesy to you, we will verify your chiropractic benefits and file claims to your insurance company. Verification of your insurance is not a guarantee of benefits or payment. Your insurance company will make the final determination of your eligibility and subsequent payments. If you disagree with any verification or payment on your behalf, it will be your responsibility to pay your account balance in full. **Any discrepancies will be handled between you and your insurance company.** Any unpaid insurance balance over **30 days** will be transferred to you and it will become your responsibility.

**Payments**: A payment is due to your account on the date of service unless other written arrangements have been approved. If there is a balance on your monthly statement, payment is due within 30 days unless other written arrangements have been approved. If no payment is made after 60 days or more, we will take necessary steps to collect this debt**. If we refer your account to a collection agency, you agree to pay your balance in full in addition of up to 66.67% in collection fees.**

**Returned Checks**: There will be a $**30.00** fee assessed for all returned checks.

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I have read and understand the financial policy and agree to all terms and conditions stated herein. I agree to make payments on my account on each date of service. I also understand that if no payment is made on my account after 60 days, my account will be subject to be sent to a collection agency/attorney and agree to pay all costs/court costs incurred if such an event should happen.

Patient's Name:_____

Responsible Party (if not the patient):_____

Patient Signature:_____ Date:_____