****

**FINANCIAL POLICY AND AGREEMENT**

I, the undersigned, in consideration of the Office’s services, agree to the following terms:

**Incorporation of Assignment Terms and Definitions.** In this Agreement, “Office” and “Clinic” shall refer to ADVANCED CHIROPRACT IC & SPORTS CARE. I have reviewed the Office’s Assignment form titled in short as “Assignment” or Assignment/Lien”. The terms and definition contained in the Assignment are incorporated herein by reference.

**Personal Responsibility for My Charges**. I understand that I remain personally responsible for my charges and that at any time; I can request a copy of my total charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my charges to the office upon its demand. I understand that Office’s Assignment does not constitute an agreement by the office to wait payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Offices right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

**Personal Responsibility for Verifying the Limitations in My Coverage: Financial Responsibility for Non-Covered Charges.**  I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, “Deny Payment”) .Without limiting the foregoing, I understand that a Payer may Deny Payment stating that the Charge is “not a covered benefit” under its policy or exceeds some other limitation. I understand that a Payer may claim based on internal criteria that a particular Charge is or was not medically necessary or was not sufficiently documented and should therefore be denied or down coded. I further understand that a Payer may require certain Charges be pre-certified or pre-authorized. I understand that there may be other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or the Office (Term of Non Coverage). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the Office. I further agree that should the Office assist me in the verification process, I assume the risk that the Payer and/or the Office may fail to accurately understand or communicate to me the Terms of Non-Coverage. Should any Payer Deny Payment or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office liable in any of the foregoing instances.

**Collection of Higher of Allowed Amounts When Two or More Payers Are Involved**. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an Assignment, to any and all Payers including, without limit, my health benefits plan. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law (“allowed fees”). I further understand that the fees allowed or utilized by one Pay may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office in so far as permitted by law to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges.

**Authorization to Sign My Name on Payments; Transfer of Credit Balances.** I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balance on my Charges to any other outstanding Charges still owed by me, my spouse or my dependants, regardless of whether these other Charges are related to my condition.

**Miscellaneous Provisions.** Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke with the Office’s consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be illegal or unenforceable, or for any reason cease to be binging on any party hereto, all other portions and provisions of this Agreement shall nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, my treatment or my Charges, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-convenient as such term is defined by law, I further waive any statute of limitations which may apply in any action based upon this Agreement, my treatment or my Charges.

I have read, understood and agree to the terms of this Agreement.

Patient Name (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_