Dakota Chiropractic & Wellness Centers' Financial Policy

1. Please sign your encounter form on every visit.
2. Our clinic staff may verify coverage, benefits and any limits on your insurance policy. When calling on benefits your insurance company only gives a general outline of benefits, not a guarantee of payment. All benefits are subject to the terms and exclusions of your policy.
3. Your insurance will make payments for any authorized and/or covered services. You are required to pay for services and materials that your insurance does not cover.
4. If your insurance requires a referral from another provider, we will require the referral number or a copy of the referral to process your insurance with in-network benefits. Until this information is provided to us, we will require you to pay all co-payments, deductibles and/or co-insurance relating to out-of-network benefits. Any overpayments to your account will be reimbursed to you after insurance pays their portion.
5. If your insurance carrier has not paid your claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid your claim within ninety (90) days of submission, you accept full responsibility for payment of any outstanding balance. If your account becomes delinquent and consequently gets forwarded to a collections agency, you accept full responsibility of all finance/collection charges in which our current charge is eighteen percent.
6. We will bill you for deductibles and co-insurance amounts, but we require payment for any pre-set co-payments or non-insurance cases at the time of service. Payment is expected at the time these charges are incurred by you at our clinic.

I have read, understand and agree to abide by the information stated above as it applies to my coverage. If special payment arrangements are necessary, they would have to be made through the clinics' billing manager. Note: All NSF checks are subject to a $25 finance charge.

Printed name: ___________________________ Signature:__________________________

Date: _________________ Dakota Chiropractic Rep.:_____________________________