Chiropractic Clinic of Three Forks

113 S. Main St. Suite A, Three Forks MT 59752, (406)285-6935

Financial Policy

It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation.

• All patient fees are expected at the time of service or according to a preset payment plan or program. Personal balances may not exceed $150 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require. *Initials* _____

All patients (except "Cash" patients, who pay at the time of service) are required to participate in **EZ Pay** whereby you authorize credit card or Electronic Funds Transfer (EFT) payments for any outstanding balance remaining after any third party payer has paid their applicable portion.

- **EZ Pay** is a secure, easy and convenient way to pay your bill. When enrolled, we debit an account for the amount you owe. Our Credit Card Merchant uses the latest encryption and security measures to ensure your payment data is protected. There is no charge to use **Auto Pay**. You can use a health savings account credit card or EFT, debit card or credit card to pay your bill. **EZ Pay** is used for any remaining balance after third party payments have been made. If the balance is greater than $150 we will give you a courtesy call prior to making the credit card charge or EFT. *Initials* _____

• Should payment be refused by your bank for any check written, this office will charge a fee up to $35 to offset the charges we will incur as a result of the returned check. *Initials* _____

• Any balance left unpaid after a period of 60 days may be assessed an interest charge of 1 percent per month. *Initials* _____

• There is a $25 fee for any appointments for which you do not show without prior notice. *Initials* _____

• Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero. *Initials* _____

CHUSA

This office participates in a discount medical plan organization, ChiroHealthUSA (CHUSA) and offers discounted fees to uninsured, underinsured, or partially insured patients who are members. We are happy to assist you in learning more about this should you wish to access these discounted fees.

Insurance Policies

As a courtesy to our patients, this office will bill third party payers, accept assignment, and wait to be paid for some portion of our patients' financial responsibility.

• The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a "Cash" patient and payment is expected at the time of service. As a courtesy to you, our office will attempt to pre-qualify your insurance coverage in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage. If we are unable to verify your insurance, a minimum of $75 must be paid at the first visit. *Initials* _____

• We cannot predict with certainty what an insurance company will pay for the usual and customary charges for services rendered. If we participate as a provider on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility. *Initials* _____

• If your insurance has not paid on an assigned bill within 60 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If the bill remains unpaid within 120 days the balance becomes due and payable immediately and your assignment is revoked. *Initials* _____

• Insurance companies must deem services as "medically necessary" to consider payment. All patients whose treatment visitation schedule is once per month or longer or outside of a doctor prescribed treatment plan is considered under "maintenance," "wellness," or "supportive" care, which is rarely covered by insurance. Our office offers numerous payment options to allow you to continue maintenance, wellness or supportive care. *Initials* _____

Signed: _____ Date: _____ Staff Initials: ____ Date: _____

EZ-Pay Authorization

I, _____, hereby authorize Chiropractic Clinic of Three Forks to initiate debit/credit card charges and/or corrections to previous debits/charges to my account with the financial institution identified by me on this form for payment of services /products rendered to me in the amount of the Balance Due.

I also hereby authorize the Chiropractic Clinic of Three Forks to initiate debit/credit card charges and/or corrections to previous debits/charges to my account with the financial institution identified by me on this form for payment of services/products rendered to me in the event:

1. My insurance company denies coverage
2. There is a remaining balance after insurance coverage has been paid
3. Or the insurance company sends payment to me and I do not bring the check to the Chiropractic Clinic of Three Forks within one week of the check's receipt.

The authorizations are to remain in effect indefinitely and may be withdrawn by me at any time by written request. I will receive an emailed receipt after any and all charges, if requested.

☐ **CREDIT CARD** on file ending in (last 4 digits) ___ ___ ___ ___ Visa®/MasterCard®/Discover® CVV:_____

Card Holder Name: _____Card Holder Signature: _____ Date: _____