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# Financial Policy

**Your First Visit**
All services rendered during the first visit and subsequent visits must be paid for at the time of service or in advance. We do not extend credit, therefore payments at the end of the week or month will not be extended. Patients without insurance coverage may pay by cash, check or credit card. Patients with insurance will need to pay for their deductible or co-pay. If your insurance has not been verified, you are on a cash basis until insurance has been confirmed. If this results in an overpayment, your account will be credited.

**Insurance Policies**
Patients with policies that the doctor is in network with are responsible for all co-payments and non-covered services. If you are coming more than one visit per week, you may pay at the beginning of the week or per visit. If the doctor is not in network with your plan, you may have out of network coverage. This coverage is usually subject to deductible, percentage, or co-pay. Any non-covered out-of-network services are the patient's responsibility.
***Deductible Policies*** are gladly accepted as long as it is verified that the 1) deductible has been met, 2) coverage has been verified, and 3) payments are made directly to our office. Please understand that insurance is an agreement between the patient and their insurance company. The agreement is not between the insurance company and this office. We will be more than happy to file, as a courtesy, the necessary forms and assist in every way, but the ***patient is ultimately responsible for all fees***.
***Supplemental/Secondary Policies*** are not filed by our office and are the responsibility of the patient.
**Please note that you, the patient, will be responsible for the deductible amount, non-covered charges and any denied visits not paid by your insurance carrier.**

**Personal Injury/Automobile Accident**
Chiropractic services are usually covered in these cases. We require that the Insurance Company verify coverage and that the accident was reported. We will bill all Insurances involved whether it be your Auto Insurance, your Health Insurance or the other persons Auto Insurance. If you do not have regular Health Insurance or Med Pay benefits on your particular Auto plan we will require you to either take care of services at each visit, beginning of the week, or obtain the services of an attorney and have a signed Lien Agreement or Letter of Protection on file with our office. If Attorney is involved, we will require a $5 per week retaining fee from you which will be due at the beginning of each week. We must have one of these in place before you can begin care with us.
**Patient is ultimately responsible for services rendered whether Insurance or Attorney pays the bill**. **If patient completes, suspends or terminates care, all fees for services are due immediately.**

**Workers Compensation "On the Job" Injury**
Workers compensation pays in full for chiropractic care. **Written verification that the accident was reported to the employer is required prior to treatment.** Our office accepts assignment unless patient suspends or terminates care, in which case **all fees for services are due immediately.**

**Medicare**
We are a participating provider with Medicare**. Medicare only pays for spinal adjustments. Any exams, x-rays, extremity adjustments, and therapies (including but not limited to: traction, spinal decompression, massage, electric stimulation, ultrasound) will be an out of pocket expense**.

**Cash Payments**
For patients without insurance coverage, our office will be happy to arrange a financial plan to suit your budget. You may pay by check, cash or credit card.

**- -Would you like pre-approval for financing, if needed, for your treatment? ____Yes ____No**

**After payment from my insurance company is received, the remaining balance must be paid at my next visit or upon receipt of a mailed statement. If payment is not received within this time period, I agree to pay all costs of collections, attorney fees, or court costs if legal action becomes necessary. I also give my permission for Dr. Ted Showalter's office to obtain any information from my Health Insurance carrier, any third party insurance carrier, or my auto insurance carrier and/or my attorney to aid in collection efforts of my account. Credits will be applied to future care.**
**I also authorize release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I have read and understood that I will be responsible for any charges that my insurance denies or deems above "reasonable and customary".**

**I_____, agree that in case that my insurance company does not pay my physician for any services rendered I will be held responsible for payment.**

Patient/Guardian Signature _____ Date_____

Witness _____ Date_____