Buchanan Chiropractic Clinic, P.C.
5124 N. Henry Blvd
Stockbridge, GA 30281
Voice: 770.474.6680 Fax: 770.474.3633

Financial Agreement

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest time possible.

Forms of Payment

Patients are responsible for full payment at the time of service. We accept cash, personal checks, Visa, MasterCard American Express, and Discover.

Insurance/Contract Services/Third Party

Other options are available if your care is covered by group health insurance, Worker's Compensation, a managed care provider, personal injury, or the result of an automobile accident.

All professional services are rendered and charged to the patient receiving care or to their insurance carrier. We will supply you and your insurance company with statements, reports, or other documents to help receive reimbursement. Please be advised insurance carriers do not guarantee payment when benefits are verified verbally. The claims are evaluated as they are received by the carrier. If you have additional questions concerning your benefits, you may wish to contact the carrier directly. While the filing of insurance is a courtesy that we extend to all our patients, all charges are your responsibility from the date that services are rendered.

We will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information.

Billing

Any outstanding balances are billed monthly and considered past due 10 days after the invoice date or when special arrangements are not met. Returned checks are subject to a $30.00 fee. **Balances older than 30 days can accrue interest charges of 1.5% per month.** Any collections costs or past due charges are the responsibility of the patient.

Patient Agreement

I have read and understand the office policies concerning Insurance filing and financial obligations of this office.

Questions

Please ask if you have any questions about this agreement or if your ability to comply with its provisions changes.

____________________________ Patient/Responsible Party Signature

____________ Date

____________________________ Office Representative

____________ Date