Arizona Center For Family and Wellness Care

Dr. N. Edwin Weathersby, DC, CCSP, DAAPM, FIACA, FICCF
Chiropractic Rehabilitation

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. ***If you do not have insurance:*** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100.00 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. ***If you do have insurance:*** All deductibles and copays are expected at the time of service or by an authorized payment plan. Your coinsurance balance may not exceed $100.00 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you notify us that you would like to file a health insurance claim. We will verify and then bill your insurance. We do not accept assignment for secondary insurance carriers but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty days of submission, you agree to take an active part in the recovery of your claim.

When your schedule of visits represents supportative care, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered or by an authorized payment plan.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: ____

Signature: ____ Date: ___________________________

Finance Counselor: _________________________________ Date: ___________________________

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