BELMONT CHIROPRACTIC CLINIC
PAYMENT PLAN

I agree to pay Belmont Chiropractic Clinic for the services received; using the following payment plan which best fits my situation:

_____PRIVATE PAY-Payment is made by cash, check or credit card.
- Payment in full for services on first visit
- Following first visit, a minimum monthly payment of $_____is due by the end of each month.

_____INSURANCE-Group or Individual health insurance.
- Payment in full of all services which apply to deductible
- All usual insurance forms are completed and submitted to the insurance company at no charge.
- Monthly statements sent to patient

_____WORKERS' COMPENSATION-Work-related injury or accident.
- Patient must provide clinic with information on employer and workers' compensation insurance carrier.
- Injury report must be completed
- In the event a claim is not considered work related, the patient is responsible for payment in full, either through health insurance or private payment.

_____PERSONAL INJURY-Auto accident or other liability injury.
- Patient must provide clinic with information on accident and insurance carrier.
- Alternate payment information must be submitted for coverage through Med Pay clause of patient's auto insurance or health insurance.

_____MEDICAID-Eligible for public assistance.
- Current eligibility card must be presented by patient before services rendered. Patient responsible for $1.00 co-payment every visit.

_____MEDICARE-65 years of age and/or enrolled in Medicare.
- We will complete and file all usual Medicare claims and secondary insurance (if applicable) at no charge.
- Patient agrees to pay any amount determined by Medicare to be the patient's responsibility.
- Medicare will pay for Spinal Adjustments only. X-rays, therapy, nutrition and supports are NOT covered.

FOR OFFICE USE ONLY: SPECIAL PAYMENT INSTRUCTIONS

☐ We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. After deductible is met, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.

☐ You are required to pay a $_____co-pay at the time of service.

☐ Benefits are available for up to _____visits per year or a maximum of $_____. A $_____co-pay is due at the time of service.

☐ A referral from your primary care physician will be necessary. Out of network benefits are available if a referral is not obtained.

I have read and understand the terms of the above-mentioned option. I understand I am personally responsible for any and all payments to the clinic or my Doctor, regardless of expected insurance payments or claim settlements. A service charge of 1.5% per month, 16% APR, with a minimum of $3.00 will be added to all overdue accounts. A late fee of $17.50 will be added to all accounts unpaid for 90 days and I am liable for all legal and collection fees.

Patient's Name:_____ Date:_____