

## **Financial Policy**

Thank you for choosing Optimum Function as your health care provider for chiropractic and massage therapy. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding or rectify an injustice.

### **PAYMENT AT TIME OF SERVICE**

Payments may be made by cash, check, Visa, MasterCard, or debit card. By paying at time of service, costly book-keeping, accountancy and billing expenses have been eliminated. However, this discount is only valid when payment for services rendered is received on the day of service. If any billing is to occur (insurance or the patient) then you will be billed at our regular office rates.

### **INSURANCE**

As a courtesy to you, we may bill your insurance carrier for you. All co-payments, deductibles, and payments for supplements, supports, and other "non-covered" services are due at time of service unless prior arrangements have been made. Payments may be made by cash, check, Visa, MasterCard, or debit card. Any unpaid balances 60 days and over will be charged interest of 2.0% per month. If you are unable to pay in full, it is your responsibility to contact us to set up an agreeable payment plan. Each patient's insurance policy is a contract between the patient and their insurance company. We are not a party to that contract.

### **UCR (USUAL AND CUSTOMARY RATES)**

Our practice is committed to providing the best treatment possible for our patients, and we charge what is usual and customary for our area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

### **INJURIES/ACCIDENTS INVOLVING LITIGATION**

We will make every effort to recover our fees from all available sources, including your health insurance and any med-pay benefits that are available on your auto insurance policy. It must be understood, however, that payment of the balance is ultimately your responsibility.

### **WORKER'S COMPENSATION**

Our office will file worker's compensation claims. It is your responsibility to contact your employer to establish a worker's compensation claim. If the claim is denied, we will bill your personal health insurance carrier. If the claim is unsettled or unpaid within 90 days, you will receive a statement from our office.

**MOTOR VEHICLE COLLISIONS**

In the state of Oregon motor vehicle accident cases are billed to your auto insurance company. An accident claim and appropriate paperwork must be filed with your insurance company prior to treatment. The insurance company may not cover 100% of the bill and you are responsible for the difference.

**MINORS**

An adult must accompany the minor at the time of the first visit. The adult accompanying the minor is responsible for payment of the account.

**MEDICARE/MEDICAL ASSISTANCE PARTICIPANTS**

We do not accept Medicare or Medicaid assignment.

**MISSED APPOINTMENTS**

We require 24 hours notice for cancellation of all appointments for both chiropractic and physical therapy. There will be a \$25.00 charge to the patient for all appointments that are missed and not canceled.

**PATIENT'S STATEMENT:**

I have read and I understand the Financial Policy of Optimum Function. I understand that I am ultimately responsible for the payment of any services or products received at this office. I also understand that I will be responsible for any fees related to collecting my unpaid balance, including reasonable attorney fees.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
(Parent or Guardian if patient is under 18 years of age)

Patient's Name  
(printed): \_\_\_\_\_