DR. JAMES B. YOUNG

Financial Agreement

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on friendly, mutual understanding between provider and patient.

It is the patient's responsibility for all payments for chiropractic care to be paid regardless of insurance coverage or time of service plans.

Our office policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made. If your account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account. If insurance coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay on a timely basis.

I understand that I will be responsible for any fees charged for checks returned for "non sufficient funds". Patient agrees to pay court and attorney fees if necessary in collecting your account.

Patient will also be financially responsible for any deductibles or co-pays/co-insurance that may apply to their insurance coverage. It is not our responsibility to know if your plan coverage includes a deductible (or if it has been met) or co-pay/co-insurance. Our office has a written "Chiropractic Billing Process" document upon request. We would be happy to bill your insurance company for any services in our office. **However, it is ultimately your responsibility to make sure chiropractic services are covered by your insurance company and that they pay in a timely manner.**

I hereby authorize payment of benefits directly to the provider by my insurance company for services rendered. I understand and written information I receive from my insurance company in regards to my care with Dr. Young will be brought to the office immediately as well as any payments made to me by my insurance company. I further authorize the physician to release any information required in order to process the insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status and/or insurance coverage.

_____ _____

Patients Name (Print) **Date**

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Patient/Patient Representative Signature

_____

Staff Signature

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