Financial Policy
of
Foxworth Chiropractic

2470 Flowood Drive, Suite 125
Flowood, MS 39232

• It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.

• All patient fees are expected at the time of service or according to a preset payment plan or program. Personal balances may not exceed $200 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require. In order to be eligible for a payment plan, a credit card must be on kept on file and run automatically in accordance to your payment plan agreement.

• For your convenience, this office accepts cash, checks, and the following credit cards:
Visa, MasterCard, American Express, Discover, Care Credit

• This office participates in a discount medical plan organization (DMPO) and offers discounted fees to uninsured, underinsured, or partially insured patients who are members. We will assist you in learning more about this should you wish to access these discounted fees.

• This office does not turn away any patient due to their ability to pay. If you feel you might qualify for our financial hardship policy, notify the office immediately so we can begin your qualification process.

• Should payment be refused by your bank for any check written, this office will charge a fee of $40 to offset the charges we will incur as a result of the returned check.

• As a courtesy to our patients, this office will bill third party payers, accept assignment, and wait to be paid for some portion of our patients' financial responsibility.

• The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a “cash” patient and payment is expected at the time of service. As a courtesy to you, our office will pre-qualify your insurance coverage, in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage.

• No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and

help estimate your responsibility.

• If your insurance has not paid on an assigned bill within 30 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 120 days the balance becomes due and payable immediately and your assignment is revoked.

• All patients whose treatment visitation schedule is once per month or longer will no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous payment options to allow you to continue maintenance, wellness or supportive care.

• Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.

• I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments and therapies rendered or provided by the above-named health care provider, regardless of its managed care network participation status. This is a direct demand for med pay, PIP, liability, UM, workers compensation, or other applicable benefits for this signed patient.

Signed: ____ Date: __________

Witness: ____ Date: ___________