Financial Policy of
Foxworth Chiropractic
2470 Flowood Drive, Suite 125
Flowood, MS 39232

- 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. 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.
- The patient or guardian agrees to pay all charges, deductibles, co-payments, and/or co- insurance amounts determined not paid or allowable by health insurance payors. Certain routine services and procedures, which are determined as necessary by the treating physician/provider, may not be covered by Medicare, Medicaid, and other third-party payors.
- 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 to be paid 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.
- A verification of your insurance is performed as a courtesy to you. However, this is not a guarantee of payment from your Insurance carrier. If denied, you are responsible for the balance owed according to the contracted fee scheduled for your insurance carrier. You will not encounter balance billing above the contracted fee schedule with your insurance carrier.
- If you do not have a Third Party Insurance, you are responsible for the bill in full at the time of service.
- It is our office policy that all balance must be paid in full 90 days after all payments have been received by your insurance. After 90 days, your account will be considered delinquent and turned over to a collection agency.

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. I agree to pay these non-covered services and/or procedures if ordered and performed by the treating physician/provider. 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: ____________