Financial Agreement

Synergy Chiropractic
Family Chiropractic Care • Sports Rehabilitation

We are committed to providing you with the best possible care. The purpose of this agreement is to clarify the financial aspects of your care. This way we can devote our efforts to helping you get the best results in the shortest amount of time. Your clear understanding of our financial policy is important to our professional relationship. We would be pleased to discuss our professional fees with you at any time.

FORMS OF PAYMENT - We accept cash, checks, and most credit cards. Patients are responsible for full payment at the time of service. Any credit arrangements must be pre authorized.

MEDICARE (Part B = Medical)

- Please be aware that you may have an unmet annual deductible. The Medicare deductible amount may change from year to year.
- Medicare only allows payment for **Manual Manipulation** of the spine for the treatment to **correct spinal Subluxation** (spinal miss-alignment). Therefore, you are responsible for payment for other adjunctive therapy services related to and necessary for the appropriate and adequate treatment of the condition. You will be informed of these additional fees in advance and you have the right to deny or refuse such therapies.
- **Medicare does not cover charges for the initial examination, x-rays and physical therapy modalities.**
- Medicare may deem your treatments "**medically un-necessary**" and therefore deny payments. You may be responsible for the denied charges.

PAYMENT PLANS - Payment plans may be arranged on a one-to-one basis during financial difficulties prior to treatment.

BILLING - Any outstanding balances are billed monthly and considered past due 15 days after the invoice date or when special arrangements are not met. Return checks are subject to a $35.00 fee. A balance older than 30 days will accrue interest charges of 1.5% per month, plus any legal or collection fees. Please be aware that your unpaid balance may be subject to be turned over to a collections agency.

PATIENT AGREEMENT - I have read and understand the above financial policy and I agree to comply under the terms described.

Patient Name	Patient/Responsible Party Signature	Date	Clinic Representative	Date
			Dr. Dilojan Abayaratna, D.C.	

Revised: 6-1-2012

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