## PATIENT FINANCIAL REPONSIBILITY AGREEMENT

Thank you for allowing Hoang Chiropractic Center to assist you with your Chiropractic Health. In the interest of goof health care practices, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patient's experience good health and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your recovery as stress-free as possible. As a courtesy to you, we will bill your insurance. If there are any changes in your insurance, please let us know immediately so we can submit your claim properly.

At Hoang Chiropractic Center we will do everything we can to verify your insurance policy prior to your visit at. Most verification can be done within 24 hours.

**We cannot accept responsibility for collecting on insurance claim after 60 days or for managing a dispute claim.** Insurance reimbursement is a contract between you, your employer and your insurance carrier. You are responsible for any charges, or portions of charges that you insurance does not pay. Payment is due at the time of services. You will begin receiving monthly statements with any balances after your insurance company has been billed. If you have any questions about your charges or statement, please contact our office at 504-263-2440. The balance of the account is due within thirty (30) days.

## Patient Responsibility Form

I, undersigned: (Patient Name) _____ have insurance coverage through (insurance company) _____ (policy#)_____, and authorize direct payment from my insurance carrier to Hoang Chiropractic Center. I also understand any portion of my bill that is not paid by the insurance for any reason is my responsibility and will pay this sum promptly to Hoang Chiropractic Center.

**Note: You are responsible for knowing your coverage benefits. Hoang Chiropractic Center will make every effort to inform you if a supply or service is not covered by your insurance. The patients are responsible to Hoang Chiropractic Center for the payment of all charges or portion of the charges your insurance does not pay regardless of reason.**

I, the undersigned: (Patient Name) _____ accept full responsibility for payment of the sum of my care at Hoang Chiropractic Center and understand the above statement and will cooperate with payment for Chiropractic care rendered. I authorized this office to contact my attorney (if applicable) or auto insurance company for information on recovery and to file a lien.

(Patient Name) _____ do not have insurance coverage and understand that I am responsible for payment of all charges.

*Collection Fees: in the event of failure to pay for the services rendered, I understand that I may be referred to a collections agency for non-payment of fees due for services rendered by Hoang Chiropractic Center. I understand that I will be responsible for 21% collection fee, all agency and attorney fees and cost associated with the collection process and that theses fees and cost will be added to my account balance. I understand that I will be responsible for paying the entire amount of my balance due in addition to the collection agency fee. Further, I understand that my PHI will necessarily be revealed in these efforts to collect payment for money owed.

_____ _____

Patient Signature or Legal Guardian Date