Dr. Shawn M. Tompkins
Chiropractic Physician

METHOD OF PAYMENT

We share the concern of our patients regarding the increasing cost of health care. Our goal is to provide you with professional service and optimize your health care dollars spent. Our fees are comparable to the usual and customary fees charged by like specialists in this area. These charges are based on the cost of services, as well as the time, and skill involved.

Payment is due for exams and x-rays regardless if insured or not. Please see information below for details concerning your particular payment status.

- **PATIENTS WITHOUT INSURANCE**
  Full payment is due at time of service.

Signature of Patient or Responsible Party _____ Date _____

- **PATIENTS WITH INSURANCE**
  Please supply complete insurance information on the day of your initial appointment. ***Failure to supply this information will require you to make full payment at the time of service.*** You are responsible for patient percentage not covered by insurance (including unmet deductibles and co-payments) on the day of service.

  Insurance companies do not guarantee benefit payments under plan provisions. Each claim is subject to all plan terms and provisions, limitations and exclusions which include, but are not limited to, medical necessity. The determination of benefits involving claims payment is made when each claim is processed. Your insurance company will be billed by our office as a courtesy to you.

  If your insurance carrier does not remit payment within 60 days, we will resubmit it for you. After 90 days if no payment has been received, we require you, **the patient**, to contact your insurance company regarding the outstanding claim. If you choose not to do so, the balance will be due in full from you immediately. Claims that are over 120 days old (4 months) automatically become the patient's responsibility and you will be billed accordingly.

I have read the Method of Payment Policy. I understand and agree to this Policy.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand that the Doctor's Office will prepare any reports and forms to assist me in collecting from my insurance and that any amount authorized to be paid to the Doctor's Office will be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care all fees for services will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care. I hereby authorize release of information necessary to file a claim with my insurance and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR CLINIC INDICATED ON THE CLAIM**. I also agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions. I attest that the above information is accurate to the best of my ability. A copy of this signature is as valid as the original.

Signature of Patient or Responsible Party _____ Date _____