



1. Financial Responsibility Policy

By receiving care at McKenzie Chiropractic, you agree to the following financial responsibilities:

- You are financially responsible for all services rendered, regardless of insurance coverage.
- Payment is due at the time of service unless other arrangements are made in writing.
- Balances over \$75 must be addressed promptly. Late payments may incur a charge of 1.5% per month (18% annually), or the maximum allowed by law.
- Prepaid packages do not expire. Pro-rata refunds will be provided if treatment becomes clinically inappropriate, the clinic relocates or closes, or the patient relocates more than 25 miles.
- If care ends, you owe only for services already rendered.
- Accounts sent to collections may include actual third-party costs if permitted by law.

2. Insurance Assignment; Authorized Representative Policy

If you choose to have us bill your insurance, you agree to the following:

- You assign insurance benefits directly to this clinic for services provided.
- You appoint the clinic as your Authorized Representative for claims and appeals, to the extent permitted by law.
- You remain responsible for deductibles, co-pays, co-insurance, and amounts not covered by insurance.
- If your insurer does not pay within 120 days, you will assist in recovery efforts. After 150 days, you are responsible for the balance.
- If care ends, you only owe for services rendered, and insurance assignment ends.

3. Cash (self-pay) Payment Election Options

This policy outlines the legally compliant methods for offering reduced rates to patients, while ensuring alignment with insurance contracts, federal/state regulations, and ethical billing practices.

Patient Signature

Date

Guardian's Signature Authorizing Care

Date

This policy outlines the legally compliant methods for offering reduced rates to patients, while ensuring alignment with insurance contracts, federal/state regulations, and ethical billing practices.

Cash Payment Election Options: Please select one of the following payment options:

Option 1: Standard Cash Pay Rate

I elect to pay for care using the clinic's published cash pay rate at a 15% discount. I understand this rate is fixed and I am choosing not to submit any claims to my insurance.

☐ I elect Option 1: Standard Cash Pay Rate with 15% discount

Option 2: Prompt Pay Discount

I elect to receive a prompt pay 24% discount for paying my entire balance on the day of service. I understand that this discount is only available when no insurance claim is submitted.

☐ I elect Option 2: Prompt Pay Discount 24% discount

Option 3: Financial Hardship Discount

I am requesting a discount due to financial hardship. I understand that I must complete a hardship application and provide documentation upon request. Discounts are subject to approval and review.

☐ I elect Option 3: Financial Hardship Discount; need based discount

Date of hardship application submission (if applicable): _____

Acknowledgment Signature

By signing below, I acknowledge and agree to the policies and options I have selected above.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Staff Witness (if applicable): _____

Date: _____