Christina Kulesz, D.C
46 Batavia City Ctr
Batavia, NY 14020

Financial Policy

1. **Unless other arrangements have been approved, payment in full is expected at the time of service.** If you have questions regarding the payment of your account, please feel free to discuss these with the chiropractic assistant or office manager.

2. **Insurance is an agreement between you and your insurance company.** If you have an arrangement with a health insurance company, as a courtesy to you, we will verify coverage and bill your insurance; however this is not a guarantee of payment. Please present your insurance card(s) so a staff member can make a copy. If payment from your insurance company is not received within 30 days of billing, the chiropractic assistant or office manager may request your assistance in obtaining payment from your insurance company. At 60 days without payment, you will become solely responsible for payment to our office of the outstanding balance as well as becoming responsible in obtaining payment from your insurance company.

3. I understand that most insurance does not cover care they do not consider "Medically Necessary". Any care I receive that my insurance considers "Maintenance or Wellness" or "Not Medically Necessary" I understand I am choosing such care and will be financially responsible for such care I receive

4. If you were/are injured on the job or in an automobile accident, we will assist you in filing the appropriate forms to open a claim. If the claim is rejected or the insurance company does not pay your bills in a timely manner, you may be required to make payments directly to us.

5. In the event of a default on your account (failure to make minimum payments when due) one or more of the following actions may be taken:
    a. Referral of your account to a collection agency (additional fees where applicable may apply).
    b. The full amount of your account is immediately due.
    c. Up to 9% interest (.75% monthly) may be added as a late fee

6. If you are unable to keep your scheduled appointment a 24 hour notice is recommended. If you do not call or keep your scheduled appointment there may be a missed appointment fee assessed and added to your account.

I, _____, certify that I have read the above financial policies and agree to these policies.

Patient Signature _____ **Date** _____

Parent or Guardian (if applicable) _____

Discover Chiropractic – One Cause, One Cure, One Correction!

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