Active Chiropractic & Rehabilitation, LLC
233 SE Washington Street Hillsboro, Oregon 97123 (503) 648-1088 (503) 648-0748 fax

FINANCIAL POLICY

METHOD OF PAYMENT: Please check appropriate circumstance and initial the Agreement Statement.

☐ CASH OR SUPERBILL. Payment at the time of service is required in order to receive our "Payment At The Time Of Service" discount. Superbill patients will be supplied with a document containing all pertinent information to submit to their insurance company and facilitate reimbursement by their insurance company.

_____ I understand that Cash and Superbill payments are due at the time of service.

☐ BILL MY AUTOMOBILE INSURANCE. If your injuries were sustained in a motor vehicle accident, your medical expenses are covered by the Personal Injury Protection (PIP) coverage of the vehicle you were in. It is our office policy and Oregon Statute to bill medical expenses to the PIP coverage of the vehicle you were in, not the other driver's PIP coverage. If you have any questions regarding this, we can refer you to the office of the Oregon Insurance Division. You must complete and submit the PIP Benefits Application supplied by the insurance company in order for medical expenses to be paid to this office. If you do not submit the PIP Benefits Application, all medical expenses become your responsibility. Any denied charges also become your financial responsibility.

_____ I understand that I am ultimately responsible for all charges, whether or not they are payable by insurance.

☐ BILL MY EMPLOYER'S WORKERS' COMPENSATION INSURANCE. If your injuries were sustained in a work related incident, your medical expenses are covered by your employer's Workers' Compensation Insurance once your claim has been accepted. Any denied charges unable to be billed to your health insurance, become your financial responsibility.

_____ I understand that I am ultimately responsible for all charges, whether or not they are payable by insurance.

☐ BILL MY HEALTH INSURANCE. Any copay, deductible, and/or percentage on your health plan are due at the time of service. Any denied charges become your financial responsibility unless prohibited by contract.

_____ I understand that I am ultimately responsible for all copay, deductible, percentage and/or charges, whether or not they are payable by insurance.

LATE CANCELLATION / NO SHOW: Chiropractic $40 Massage $35 ½-hr $65 1-hour

In order to avoid a late cancellation or no show fee for missed appointments a 24-hour notice is required. These charges are not payable by any insurance company.

_____ I understand that a Late Cancellation or No Show fee may be charged for cancellations without 24-hour prior notification.

NON-SUFFICIENT FUNDS: $25

In the event that your check is returned due to non-sufficient funds in your account, you will be charged an administrative processing fee.

_____ I understand that a processing fee will be applied to my account if my check is returned due to non-sufficient funds.

Patient/Guardian Signature:_____ **Date**:_____