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) _______________ do not have insurance coverage and understand that I am responsible for payment of all fees, charges, cost and expenses incurred in connection with my chiropractic care at Hoang Chiropractic Center.

Payment is due at the time services are rendered. A 3.95% processing fee applies to debit and credit card payment transactions.
The 3.95% fee is waived when paying by ACH, cash or check. ________ (initial)

I, the undersigned: (Patient Name) ________________ have a claim against a third party for injuries sustained in an accident which occurred on or about _________,20____. I accept full responsibility for payments of all fees, charges, cost, and expenses incurred in connections with my chiropractic care at Hoang Chiropractic Center arising out of the injuries sustained in said accident. I understand Hoang Chiropractic Center is entitled to a privilege or lien under La.R.S.9:4752 on proceeds collected from a third party for services rendered to an injured person or will cooperate with Hoang Chiropractic Center to contact my attorney (if applicable) or auto insurance company for information on the status of the case and to file a lien. I understand that this privilege or lien in no way limits my responsibility to pay for chiropractic care rendered.

I, the undersigned: (Patient Name) ________________ will opt out of filing my health insurance ____________ for injuries sustained in an accident which occurred on or about ____________________.