

# PRIMARY CARE & CHIROPRACTIC CENTER

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## FINANCIAL AGREEMENT, POLICY ON FEE SCHEDULES & PAYMENTS

Our office offers two methods of payment for services delivered. Please check one of the following.

**SELF-PAY PLAN**

Definition: Under this payment method, charges for services are paid in full immediately after they are delivered, and no paper work is performed, other than a receipt, and no insurance codes will be utilized.

**INSURANCE PLAN**

Definition: The fee schedule is higher than the SELF-PAY PLAN as the INSURANCE PLAN requires considerable insurance billing, copying of records, report writing for medical necessity and completion of forms. Charges will be billed to your insurance company. Deductible and Co-pay if applicable is due at the time of the visit. **CODES ARE BILLED BY THE FEE SCHEDULE SET BY THE STATE OF COLORADO WORKERS COMPENSATION COMMISSION.**

- **VERIFICATION OF COVERAGE IS NOT A GUARANTEE OF BENEFITS OR PAYMENT. ACTUAL PLAN COVERAGE AND BENEFITS IS BASED UPON MEDICAL NECESSITY AND DETERMINED BY YOUR CARRIER UPON RECEIPT OF THE CLAIM FOR YOUR DATE OF SERVICE.**
- **PAYMENT PROCEDURE** - Our office requires payment at the time of each visit unless the patient is covered by health insurance which pays to our office, and this office has received VALID INSURANCE INFORMATION OR REFERRAL (when applicable). If you wish us to file your insurance for you, we will do so.
- **CO-PAYMENT/CO-INSURANCE IS DUE AT THE TIME OF SERVICE.** We are happy to accept payment by cash, check, or credit card (VISA, MASTER CARD).
- **IT IS YOUR RESPONSIBILITY TO HAVE YOUR REFERRAL @ THE TIME OF YOUR VISIT (IF NEEDED), OTHERWISE YOU MAY BE HELD RESPONSIBLE FOR PAYMENT.**

**NOTE:** Our financial relationship is with **YOU**, not with your insurance company. When we verify benefits, and as a courtesy to you, we will try to give you general guidelines about what your insurance policy might cover. Since insurance is a agreement entered into by you and your insurance carrier, you are ultimately responsible for knowing the specifics of what your policy covers.

***All patient portions of accounts past due for 60 days or greater will be assessed an interest penalty of 1.5% monthly. This is an annual percentage rate of 18%.***

**CANCELLATION FEE** - If you need to cancel or reschedule your appointment (chiropractic/acupuncture/massage), please call us twenty-four hours prior to your appointment, **or you will be charged a \$25.00 cancellation/no-show-fee.** Exceptions may be made for emergency situations.

I agree to the above selected payment schedule, and accept my responsibility as outlined in my selection.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date