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Financial Policy

4523 Hixson Pike
Suite 104
Hixson, TN. 37343

This is an agreement between The Hixson Spine Center of Chattanooga, Inc. , a Tennessee Professional Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer The Hixson Spine Center of Chattanooga, Inc.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have no insurance:
You choose to pay by __cash, __check, or __credit card on the day that treatment is rendered.

Payment options if you have insurance:
1. You choose to pay your deductible and any out-of-pocket portions at the time services are rendered by __cash, __check, or __credit card.

2. On Personal Injury cases, if we have to wait for a settlement in order for services to be paid, you agree to pay for at least 50% fees for care by __cash, __check, or __credit card. In addition you authorize The Hixson Spine Center to check your credit report.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Contracted Insurance:
If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Finance Charge: A finance charge will be imposed on each item of your account, which has not been paid within ninety (90) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twenty one (21%) percent. The finance charge on your account is computed by applying the periodic rate (1.75%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50.

Credit History: If we have to work on a credit basis, (EX: we provide service until personal injury case is settled or insurance is filed), you give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau. We reserve the right to issue you service on a credit basis or to refuse you service on a credit basis.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned checks: There is a fee (currently $35) for any checks returned by the bank.

Missed Appointment and No-Show fee: Patients who do not show up on time for an appointment, or cancel with less than 12 hours notice will be charged a $35.00 fee. This fee must be paid before a new appointment is scheduled. Patients with 3 no show appointments will be taken off the schedule until all no-show fees are paid.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all court costs. In case of suit, you agree the venue shall be in Chattanooga, Tennessee.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent responsibility to collect from the other parent. *(Authorizing parent means you brought the child for care.)*

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your motor vehicle insurance policy for med-pay benefits or your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

I understand that with all medical procedures there are risks. Chiropractic manipulation although is very safe procedure it is not risk free. The statistics are approximately one out of one hundred million people could suffer a stroke from a cervical spinal manipulations. Spinal manipulations could also cause muscle soreness, and/or increase pain at times. I recognize and acknowledge that there are certain risks to chiropractic manipulation and I agree to assume the full risk of any injuries, including death, damages or loss which I may sustain as a result of treatment rendered. I further agree to indemnify and hold harmless and defend the Hixson Spine Center and its officials, officers, agents, employees from any and all claims resulting from injuries, including death, damages, and losses sustained from treatment.

Patient's name: _____

Responsible party
(if not the patient): _____

Signature:_____ Date:_____

Co-Signature:_____ Date:_____