Advanced Chiropractic Relief

Dr. Gregory E. Johnson, D.C.

FINANCIAL AGREEMENT

PATIENT NAME:_____DOB_____INSURANCE_____

Services provided by Dr. Gregory E. Johnson, D.C., DBA, Advanced Chiropractic Relief are due at the time of service unless otherwise agreed upon by the parties in writing. Services within this practice will be considered out of network. An explanation of benefits (EOB) will be sent to you from your insurance company, informing you of your out of network benefits. This is only a notification to you of what your insurance company considers as allowed charges and what percentage of these charges they will cover. **This is not a bill from me, the provider.**

In appreciation for you entrusting your care to me, I do not want you to be penalized for choosing me as your provider, therefore you may be eligible for discounts based on financial needs. With this in mind, once you receive a statement from this office, please bring it in, to discuss your account in detail.

Coinsurance and deductible _____**Our Legal Responsibilities**

Please understand that there are legal requirements placed upon us; "reasonable efforts" to collect any outstanding balance that your insurance company does not pay.

I do not want to compromise or settle for anything less than excellent chiropractic care and rehabilitation because of financial concerns. I understand the difficulties that a patient can face and it is my heartfelt desire to deliver the highest quality of chiropractic care and rehabilitation, and to do so in a manner that relieves financial burdens on you.

Based on the information provided by you and your insurance company (ies), I have agreed to initiating a payment arrangement with you in an effort to fulfill your financial responsibilities for services rendered to you by me.

My remaining deductible is: $____, I will pay $____ today, I agree to pay what the insurance company doesn't allow upon receiving the explanation of benefits, (EOB). I agree to pay monthly payments of: $____ until my balance is paid off. I cannot determine exactly what your insurance company (ies) will pay until I receive the payment and EOB(s) from your insurance company (ies).

*Please be advised that any monetary credit as a result of your payment to me will be credited toward your deductible(s), co-pay(s) and applied to any outstanding balance on your account.

My payments each visit will be: $____ and upon receiving the EOB from your insurance company (ies), I agree to pay this balance in monthly payments of: $____ beginning on or before the ____(date) of each month.

If you are unable to satisfy this payment arrangement for any reason, please contact me immediately.

Assignment of Benefits/Insurance Payments

I hereby assign all health insurance benefits to be paid directly to: Dr. Gregory E. Johnson., D.C. DBA, Advanced Chiropractic Relief. If any insurance company (ies) sends me the payment, I understand and agree that I must forward that payment to Dr. Gregory E. Johnson, D.C., DBA, Advanced Chiropractic Relief immediately along with the explanation of benefits, (EOB). I understand and agree, that I must endorse said payment (check), received from any insurance company (ies) for services rendered to me by you, immediately. You can bring in the endorsed check personally or by US mail, to:

Dr. Gregory E. Johnson, D.C.

363 N Sam Houston Parkway E Suite 1100

Houston, Texas 77060

_____ _____ ___/__/___

Patient Signature **Print Patient Name** **Date**