



## Financial Policy

Thank you for choosing Williams Chiropractic as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

All payments are due at the time of service. We accept cash, check, Visa, and MasterCard.

We accept assignment of insurance benefits from your insurance carrier; however it is YOUR responsibility to ensure that your insurance carrier meets their obligations. Health insurance is a contract between you and your insurance carrier. We are not a party to that contract. All insurance carriers will be called, and coverage or non-coverage determined, by Williams Chiropractic. If your insurance company has not paid within 45 days, you will be asked to make a payment on the account to stay in good standing with Williams Chiropractic. We encourage you to contact your insurance company for any discrepancies.

If we are a participating provider, ALL CO-PAYS and DEDUCTIBLES are due the day of treatment, unless arrangements are made PRIOR to treatment.

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment if full regardless of any insurance company's arbitrary determination of usual and customary rates. In the event your insurance company does not make payment, you are fully responsible for the balance on your account. We are not required to take adjustments for ALL insurance companies and reserve the right to deny adjustments for those networks we are not contracted. Please contact your insurance carrier to determine if we are an in-network or out-of-network provider and if we are contracted with them and their networks.

We ask that all appointments be cancelled at least 24 hours in advance; we reserve the right to charge for missed appointments with a \$25.00 fee.

**\*\*We reserve the right to charge a monthly late fee in the amount of \$5.00 for accounts with balances older than 60 days.\*\***

If you require payment arrangements, please see the front desk.

By signing below, you indicate you have read the financial policy and agree to the terms of this agreement.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature of Co-Responsible Party

**13900 W. Wainwright Dr. • Boise, ID 83713**

**208.888.2278 or 208.344.1851**