FINANCIAL POLICY

For Champaign Chiropractic Clinic

The following statement is our Financial Policy. It is required that the patient and/or responsible party read and sign this statement prior to any treatment.

Co-Pays

All co-pays and deductibles are due at time of service. If you are unable or unwilling to pay the co-pay, your appointment will be rescheduled until such a time that you can pay the co-pay.

Workers' Compensation

You must notify us prior to being seen by the physician if we are seeing you for a work related injury. Your employer must complete and sign an "employer's worker's compensation acknowledgement" form. It is your responsibility to being this completed form with you along with all billing information for your account (carrier name and address, contact person, telephone number and claim number if applicable). This information must be provided to us prior to treatment.

Liability Injury

If you are being seen due to a liability injury you must provide the following information for billing and verification of payment prior to treatment:

*auto accident: if you were injured in your own car you must provide us with the name and address of your auto insurance company, your agent/adjuster's name, telephone number, your claim number and date of accident. If your injury occurred in someone else's car, we require all of the above information "and" the following, their name, the name and address of their auto insurance company, their agent/adjuster's name, telephone number and their claim number. We do not bill 3rd party insurance.

*slip and fall, etc: if you were injured on residential property or in a residential dwelling, we require the following, homeowner's name , the name and address of their homeowner's insurance company, their agent/adjuster's name, telephone number, their claim number and the date of accident. If your injury occurred at a place of business, please provide basically the same information.

Delinquent Account

You understand that your balance is due upon receipt of your statement. If you do not pay the balance in full within 60 days of the statement, your account will become delinquent. You agree to pay a finance charge at the

rate of 1 1\2% per month (18% per year) on all unpaid balances commencing 60 days from the date of service. You also agree to pay a $20.00 service charge on all returned checks.

Collection Costs and Procedures

I agree to pay all reasonable costs you incur to collect this debt. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency costs, service fees, and other related collection costs or contingencies. I understand that if any unpaid balance is turned over to our collection agency that a fee ranging from 30%-50% will be added to the total balance due. I hereby give you or any of your agents or assignees to whom you turnover any unpaid balance permission to obtain a report from a credit reporting agency and to take reasonable steps to verify my credit and or employment information. I give you or any of your agents or assignees to whom you turnover any unpaid balance to contact me regarding this transaction or any future transaction at any telephone numbers of which they are aware including cellular telephones by manually dialing, using an auto-dialer or pre-recorded message.

By signing below you affirm that you read and understood our Financial Policy and that you agree to its contents.

______________________________ ____________________

Signature of patient or responsible party Date