TEXAS BACK CARE
Dr. Carl M. Naehritz III, D.C. & Assoc.
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BEDFORD, TEXAS 76021
(817) 545-1100 FAX (817) 545-1101

PATIENT FINANACIAL PROGRAM

Unless specific arrangements are made in advance, **payment-in-full** is expected at the time of each visit. We wish to make available as many reasonable options for payment as possible. So that you understand what programs are available, on a standard basis, we provide this brief explanation. We are of course, most aware of extenuating circumstances that necessitate a payment program. Do not hesitate to ask us about such a program.
We must have payment for supplies at the time they are prescribed. We are more than willing to make any special arrangements with you that are feasible,

_____ **ON THE JOB INJURY:** I was injured at work, and this claim is being submitted under my employer's Worker's Compensation Insurance. In the event that this claim should be rejected by that carrier, I understand that I am liable for payment of all treatment and services charge.
(**Patient Initials) _____**

_____ **PERSONAL INJURY:** I was injured in an auto accident, slip and fall or personal injury and this claim is being submitted through auto insurance. In the event this claim should be rejected by that carrier, I understand that I am liable for payment of all treatment and services charges.
(Patient Initials)_____

_____**INSURANCE ASSIGNMENT:** I have insurance and will make assignment to the doctor and/or clinic.

_____**DEDUCTIBLE:** My deductible is $_____. I have_____/have not _____ met my deductible for the calendar year.

IF AT ANY TIME DURING MY TREATMENT I CHOOSE TO SWITCH DOCTORS, I UNDERSTAND THAT MY BALNCE IS **DUE IN FULL**, BEFORE ANY RECORDS ARE RELEASED FROM THIS CLINIC.
(Patient Initials)_____

ESTIMATED PATIENT PORTION: In addition to my deductible, I understand that I am responsible for any amount not covered by my insurance policy(s). I will pay the estimated portion of my bill on a weekly basis.

PATIENT PORTION: The doctor and/or clinic shall receive the checks from my insurance carrier and any amount due over the amount paid by me shall be added to the **ESTIMATED PATIENT PORTION** and paid as stated above.

REDUCTIONS AND REJECTIONS OF CLAIMS BY MY INSURANCE CARRIER DO NOT IN ANY WAY EFFECT MY OBLIGATION TO PAY THE BILL IN FULL.

_____**CASH AGREEMENT:** I will make payment in full for services rendered on my first visit and on a weekly basis thereafter.
(Patient Initials)_____

WE ACCEPT VISA, DISCOVER, MATERCARD AND AMERICAN EXPRESS

NOTICE: Eighty-three hundredth of one percent interest per month is charged on all unpaid balances carrier over thirty days. Accounts sixty days past due, without written financial arrangements are immediately sent for collections.