



**DEMETREE
CHIROPRACTIC
GROUP**

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DEMETREE CHIROPRACTIC GROUP
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FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time the services are rendered **UNLESS** we are contracted to your insurance through a **PPO** or **HMO** insurance plan. For those patients with **PPO/HMO PLANS**, we remind you that you are responsible for your co-pay/deductible and non-covered services. We accept cash, checks, MasterCard or Visa. We will be happy to file you insurance as a courtesy to you for reimbursement. In special instances we **MAY** accept assignment of insurance benefits.

Return checks are subject to and additional fee of \$25.00

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a "percentage" (such as 50%, or 80%) of "UCR". "UCR" is defined as "usual, customary and reasonable" fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and the cost of care in this area.
3. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical providers, our relationship is with you, not your insurance company (excluding contracted PPO and HMO plans). While the filing of insurance claims is a courtesy that we extend to our patients, all charges are **YOUR** responsibility as of the date the service is rendered.

LATE CHARGES

If I do not pay the entire outstanding balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

PRINT NAME

DATE

SIGNATURE