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Prepared: 3/6/13

**Payment Plan for Patient with a Balance/High Deductible Coverage**

As a current or prospective patient of (doctor’s office) (hereinafter referred to as “doctor”) who is presently without any *insurance/participating in a high deductible insurance plan/has an outstanding balance* (choose appropriate situation) for chiropractic services, I hereby acknowledge and agree to the following payment plan:

**Payment Terms**.

 Patient understands and agrees that he/she will be paying for all chiropractic services and recommended products at the time of the service. As a patient making immediate payment, they will receive a discount on both covered and non-covered services. As directed by the patient, claims for all services and products will not be submitted by the doctor to any insurance provider. Patient assumes complete responsibility for submitting claims or otherwise complying with all terms of any applicable insurance policy.

*(Optional: A current schedule of fee/charges under the terms of this agreement is attached at Exhibit “A”. Patient understands that such schedule may be modified in the future. )*

(Optional for Patient with outstanding balance:) Patient acknowledges that they presently have an outstanding balance owed to the doctor for chiropractic services in the amount of $ . Patient knowingly, freely, and voluntarily enters into this agreement describing terms for payment of this past due balance and any future chiropractic services. Patient agrees to pay such balance to the doctor in the following manner: (describe amount due and payable on specified date of each month with commencement and ending date) .

Patient understands that timely payment is necessary in order to comply with the terms of this agreement. Patient understands that interest will/will not be charged for any outstanding balance which is not timely paid, as described below. Patient further understands and agrees that doctor reserves the all legal right to recover amounts due for chiropractic services and that the doctor can take all appropriate legal action should the patient fail to comply with these payment terms.

**Manner of Payment**. Payments under the terms of this agreement can be made by cash, certified funds, or the following credit cards: . All such payments can be mailed or delivered to the following address of the doctor: . Payments shall be regarded as actually paid by the patient on such date when received by the doctor. Patient is advised to allow time for regular mail service when submitting payments.

**Time of Payment**. All payments for chiropractic services and products shall be paid at the time of service or as otherwise mutually agreed by the doctor and patient, as stated in this agreement. If requested in writing by the patient, doctor will provide receipt(s) for all payments made and monthly statement(s) for any outstanding balances.

**Failure of Payment**. If payments are not made in a timely manner, patient understands that the doctor may terminate care. Patient also agrees that any portion of the balance which is not paid more than thirty (30) days after a statement date or due date described in this agreement shall be regarded as past due and subject to an interest charge. The interest charge will be % (per month/per year) simple interest as applied to the past due amount. Patient understands that it is his/her responsibility to promptly notify the office of any disputes which they may have relating to an outstanding charge for all chiropractic services.

The undersigned patient/patient representative acknowledges reading this agreement and is freely and voluntarily agreeing to sign this agreement as acknowledgment and acceptance of all terms and provisions of this agreement.

Date:

 Patient/Authorized Representative

 Relationship of Authorized Representative

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