

**Dr. Fred E. Russo C.C.S.P.**

Tallahassee Chiropractic Sports Medicine & Rehab Center

230 John Knox Rd #3 Tallahassee, FL 32303 Phone (850) 422-2225 Fax (850) 422-2509

**Financial Policy**

Self Pay: Patients who do not have insurance, or do not wish to have their insurance billed are considered Self Pay. Payment in full is expected at the time of service.

Major Medical /Group / Individual Insurance: As a courtesy to you, we will file your insurance and accept assignment of benefits. In order for us to provide this service to you, it is imperative that you provide us with current and accurate insurance information. If you provide us with inaccurate insurance information, or the insurance company fails to process your claim within 90 days, you will be held responsible for immediate payment. Please be aware that some services may be non-covered services, you will be responsible for payment of those services.

You are responsible for paying your deductible and co-payment at the time of service. However, if you are on a treatment plan that requires you to visit our office more than one time per week, you may make weekly payments. We accept payment by cash, personal check, Visa, MasterCard, American Express, or Discover.

If you are insured by an insurance plan for which we are participating providers, we will file your insurance and make the appropriate adjustments. You are expected to pay your deductible and co-payment at the time of service or on a weekly basis as described above.

- Any payment arrangement other than those noted above must be approved by the Office Manager.
- If you discontinue care, the balance of your account is due and payable immediately even if your insurance has been filed. When your insurance makes payment, a refund will be mailed to you immediately. No X-rays or records will be released to another doctor until your account is paid in full.
- Our office will not enter into a dispute with your insurance company over your claim.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

In addition to the above financial policy, I hereby authorize Tallahassee Chiropractic Sports Medicine and Rehab Center to automatically charge my credit/debit card listed below if any payments become 45 days past due. Furthermore, I agree not to dispute these charges with the credit card company.

Circle one:    Visa            MasterCard            Discover            American Express

Credit card company name: \_\_\_\_\_

Card Number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_