**MARK E. COTNEY, D.C., P.C.**
# Thomaston Chiropractic Clinic
**101 North Green Street**
**Thomaston, Ga 30286**
**Phone 706-647-2225 Fax 706-648-2153**

## FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the best chiropractic care available. Your clear understanding of our financial policy is important to our professional relationship. We welcome open discussion about our fees and your responsibility for your bill.

Full payment is due at time of service. We accept cash, checks, Visa, MasterCard, Discover and American Express.

**INSURANCE**
We will gladly accept assignment of your insurance benefits after verification of your insurance policy regarding chiropractic care. It is your responsibility to provide our office with your insurance card and any special forms that your insurance company may require. **WE WILL FILE YOUR INSURANCE AS A COURTESY TO YOU, HOWEVER, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL AND MAKING SURE IT IS PAID. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR COMPANY AND WE CAN NOT BE RESPONSIBLE FOR ANY PROBLEMS THAT MAY OCCUR WITH YOUR INSURANCE COMPANY. IF YOUR COMPANY HAS NOT PAID YOUR BILL AFTER 60 DAYS WE EXPECT PAYMENT FROM YOU.**

**CHILDRENS/MINORS**
The adult accompanying a minor patient will be responsible for payment at time of service unless other arrangements are made prior to the day of service.

**MISSED APPOINTMENTS**
There will be a $30.00 charge for missed appointments unless a 24 hour notice is given.

**DELIQUENT ACCOUNTS**
Accounts over and past due after 90 days are considered delinquent and will be charged a 1.5% interest per month until the bill is paid in full.

**INSURANCE ASSIGNMENT**
I hereby authorize and direct my insurance company/attorney to pay directly to Mark E. Cotney, D.C., P.C. such sums as may be due in owing this office for services rendered to me by reason of accident, illness, or by reason of any other bills that are due this office. I further give authorization to this office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under assignment. I agree the above mentioned office be given power of attorney to endorse/sign my name on any insurance check for payment of my doctor bill. I further understand and agree that if this office must take action to collect an outstanding balance on my account I will be responsible for payment of and will reimburse this office for all cost of such collection efforts, including but not limited to court cost and attorney fees.

I have read the above and fully understand it.

_____ _____
PATIENT DATE