ALTERNATIVE HEALTHCARE SOLUTIONS
TREATMENT AGREEMENT

Dear patient,
Every once in a while we have a patient who complains about their bills and each time they are really just angry with their insurance company. Still, no one likes to get a surprise bill in the mail and we don't like unhappy patients. For this reason, I will need for you to read and sign our treatment agreement as a prior condition to beginning treatment.

PLEASE NOTE!

Despite what the insurance company has said they will cover, there is no guarantee until the bill is actually submitted. It is rare but it does happen that an insurance company will say one thing and then not honor what they have said they will cover. Please read the following carefully and sign the bottom if you understand and agree.

☑ WE ARE **NOT** A PREFERRED PROVIDER FOR ANY INSURANCE COMPANY.

☑ WE ACCEPT ASSIGNMENT FOR BWC, MEDICARE AND MEDICAID ONLY **AND THAT IS IT!**

☑ **WE WILL BILL YOUR INSURANCE COMPANY BUT YOU ARE 100% RESPONSIBLE FOR THE BALANCE THEY DON'T PAY.**

☑ WHATEVER YOUR INSURANCE COMPANY DOES OR DOES NOT PAY IS NOT OUR PROBLEM… IT IS YOURS AND YOU ARE 100% RESPONSIBLE FOR PAYING YOUR BILL IN A TIMELY MANNER.

☑ YOU, THE PATIENT ARE 100% RESPONSIBLE FOR CHECKING WITH YOUR INSURANCE COMPANY AS TO WHAT THEY WILL AND WILL NOT COVER.

☑ INTEREST AND COLLECTION CHARGES UP TO 30% WILL BE ADDED TO YOUR BILL IF IT BECOMES OVERDUE BY MORE THAN 90 DAYS FROM THE INITIAL TREATMENT DATE.

☑ **INSURANCE PRICES:** YOUR INITIAL EVALUATION AND TREATMENT CHARGE WILL BE $255.00. ALL REMAINING VISITS WILL BE $200.00.

☑ IF PAYING CASH EACH VISIT AND NOT GOING THROUGH YOUR INSURANCE, $200.00 FOR THE INITIAL AND $150.00 FOR VISITS AFTER THAT. ONCE WE BILL THE INSURANCE, THERE IS NO SWITCHING BACK TO THE CASH PRICE.

☑ WE WILL **NOT UNDER ANY CIRCUMSTANCES** GIVE A LETTER OF PROTECTION TO YOUR LAWYER. OR WAIT TILL YOUR ACCIDENT CLAIM HAS BEEN SETTLED. YOU ARE RESPONSIBLE!!!

☑ I HAVE READ THE TREATMENT AGREEMENT AND THE BILLING POLICY AND **I AGREE TO ABIDE BY THEM AS A PRE-CONDITION TO BEGINNING TREATMENT.**

AGREED BY_____DATE_____

I DO NOT AGREE AND WILL SEEK OUT ANOTHER PROVIDER FOR MY SERVICES._____DATE_____