Amon Chiropractic & Wellness Center **Dr. Sheila Amon**
10605 Concord Street, Suite 502 240-242-3266
Kensington, Maryland 20895 (fax) 240-242-3248

FINANCIAL AGREEMENT

I, _____, have requested treatment from the office of Dr. Sheila Amon, Amon Chiropractic & Wellness Center and YourSpine, L.L.C. I have read and understand the following:

1. I am responsible for all co-payments, deductibles, and co-insurances as per the terms of contract with my insurance carrier.
2. All co-payments must be paid at the time of service. This includes multiple co-payments, if required by my insurance carrier.
3. I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
4. I am responsible for updating my health insurance information with the office any time the information changes/terminates/new coverage begins. The office will submit my medical claim for me as per the terms of the contract with my insurance carrier.
5. The office is restricted to a "timely filing period." I understand that I must supply the office with my health insurance card in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my health insurance information in a timely fashion is my responsibility and I will agree to make payment.
6. A check returned from my financial institution is subject to a returned check fee of $35 in addition to the previous amount of the check. After two (2) returned checks, I agree to make all payments by cash or money order.
7. I agree to pay a fee of **$50** for a missed/late/cancelled regular appointment if I do not notify the office of cancellation 24 hours in advance.
8. I am responsible for my minor child's co-payments and/or all non-covered charges. Payment will be made at the time of service unless a payment plan is in agreement with myself, Dr. Sheila Amon, Amon Chiropractic Center and/or YourSpine, L.L.C.
9. If there is an outstanding balance and my bill is sent to collections, I understand that I will be responsible for the balance of my bill, 18% interest, court costs and any other costs that Dr. Sheila Amon, Amon Chiropractic & Wellness Center and/or YourSpine, L.L.C. will incur while attempting to have my bill paid.

_____ _____
Patient Signature/Guardian Signature if applicable Date

Printed Name_____