DR. STEVEN D. LEHMANN
LEHMANN CHIROPRACTIC CENTER
231 WEST TIFFIN STREET
FOSTORIA, OHIO 44830
TEL: (419) 435-2900
FAX: (419) 435-2901

FINANCIAL POLICY

General Payment:

- All charges for services rendered in the office will be due and payable within 30 days from the date of invoice.
- You are responsible for verifying that Lehmann Chiropractic Center is in network with your insurance company.
- If your insurance company does not pay on your account due to non-covered service or required information no obtained from the insured within 90 day of your date of service, the balance will be transferred to your account and it will be your responsibility to pay in full by the statement due date.
- Co-payments required by the insurance carriers are due at the time of service. In the event of an overpayment, a refund will be made to you in a timely manner.
- If you do not have insurance and are unable to pay in full at the time of service, payment arrangements must be made with Dr. Lehmann by the end of your first appointment.

Insurance:

- As a courtesy, we will submit claims to your insurance company(s).
- Any balance remaining after processing the claim by your carrier is your responsibility.
- It is your responsibility to know your insurance benefits; they may not cover all services. Your insurance policy is a contract between you, your employer and your insurance company.
- It is your responsibility to provide us with the insurance card on the day of your appointment.

Work Related Injuries:

- Lehmann Chiropractic Center will file Workers' Compensation claims on your behalf.
- Authorization is required from your employer or the Ohio BWC prior to service
- If prior authorization is not obtained or services are performed that are not covered by your employer, you will be responsible for all charges.

Divorce:

- In the case of divorce, the responsibility for payment of services rendered to any dependent child is the responsibility of the parent who seeks treatment.

Acknowledgement of Financial Policy – Assignment of Benefits – Authorization to Treat

I hereby acknowledge receipt and agreement to the financial policy of Lehmann Chiropractic Center. I authorize the provider of medical/chiropractic services to release information for services to my insurance carrier, attorney or any other agency providing service or benefits in order to review or process claim. I furthermore authorize payment of benefits be made directly to the provider.

I agree that I will be responsible to pay for any portion of the charges not covered by my insurance. I agree that in an unfavorable judgment by the Ohio BWC that unpaid bills will still be my responsibility as allowed by the Ohio Revised code. If I fail to pay the outstanding balance within 90 days of the due date, I understand that my obligation may be referred to a third party collection agency or attorney. I also understand that I will be responsible for all collection fees, interest and other expenses necessary to collect on my account including court cost should legal action be taken against me or responsible party. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

The information set forth above is true to the best of my knowledge and I acknowledge that I have read, understand and agree to all of the terms set forth above.

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Printed Name	Signature of Patient or Patient's Representative (if minor or physically incapacitated)	Date