FINANCIAL POLICY AND AGREEMENT

Advantage Chiropractic and Massage Therapy

I, the undersigned, in consideration of the office's services, agree to the following terms:

Definitions, in this agreement, "Office" and "Clinic" shall refer to Douglas Smith, P.C., D.B.A. Advantage Chiropractic and Massage Therapy located at 400 Holiday Court, Suite 106, Warrenton, VA 20186. "Financial Policy" or "Agreement" shall refer to this document. "Payer" shall refer to a third-party payer/ insurance company.

Authorization to Sign My Name on Payments; Transfer or Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges Incurred by me, my spouse, or my dependents. In such cases, my printed name followed by the phrase, "(by Advantage Chiropractic and Massage Therapy)," shall serve as a property authorized endorsement. I further authorize the Office to apply any credit balances on my Personal Responsible Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. I agree that any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment regardless of any such terms or restrictions indicated on, or included with any payments. I also agree that my account with your Office shall be constructed as in "default" on the earlier of the following dates; (a) a payer fails to pay any or all of the charges in full and directly to the Office upon receipt of those charges within thirty (30) days or the period established by the earliest prompt deadline applicable to the payer (whichever occurs earlier), (b) I do not pay any and all of these charges in full within fourteen (14) days of request, or (c) the office attempts to charge my credit card with compliance with a written arrangement, but the charge is declined or not approved.

Personal Responsibility for Verify the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example, without limiting this Agreement, I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a payer may Dent Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or down coded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further agree to the terms of the Office's Auto/Work Comp Advance Beneficiary Notices as applicable. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verify all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can request copies or the Offices verification (e.g. eligibility, pre-authorization) forms to gain further understanding. I agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the forgoing instances.

Directions to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any

and all Payer, including without limit in accident cases my health benefit plan, but not including Medicare. Notwithstanding the foregoing. In the event that the Office determine in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are Imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws to the extent permitted by the law. In the event that no Mandatory Fee Reductions are actually Imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Miscellaneous Provisions. Except as provided int his paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this agreement. I agree that each and every provision of this agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum incontinence. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien". Health Insurance Election, and, if applicable, Auto/Work Comp Advance Beneficiary Notices, and further agree to the forms and definitions set forth in these documents as applicable. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filling and termination liens, and submitting notices of same to Payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____

Date: _____/_____/_____

Patient Signature: _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print):

_____

Parent/Guardian Signature: _____

Date: _____/_____/_____