FINANCIAL POLICY

At Dakota Health Solutions we are committed to offering the finest quality chiropractic neurology, functional medicine, and wellness health care services to our patients. It is our policy that our patients are charged fees that are reasonable and economically feasible for both the clinic, and our patients.

To achieve these goals and to assure continued quality service we must ask for your help.

The responsibility for payment for our fees lies directly with the patient. It is NOT the clinic's responsibility to act as a patient's agent in negotiating payment from insurance companies or Medicare. However, we will send all insurance covered service charges to your insurance company on your behalf.

Patients are expected to pay at the time of service. The exceptions would be patients receiving insurance covered services under a worker's compensation claim, personal injury claim, an auto accident, Blue Cross Blue Shield, or Medicare. Co-payments and non-insurance covered services will be collected at the time of service. The specific services provided by Dakota Health Solutions that are not covered by insurance due to the functional nature of its diagnostic/therapeutic use and therefore the patient's responsibility include:

- Videonystagmography (VNG)
- Intense Functional Neurology Assessment Protocol (IFNAP)
- Diagnostic Laboratory Testing
- Bio Impedance Analysis (BIA)
- Acupuncture
- Report of Findings (ROF)
- Nutrition Consultation
- Supplements

Monthly statements are sent to inform our patients of their status of their account. It is also a request for payment of all charges that have not been paid for. In the event insurance and personal payment exceeds our fees, a refund will be issued to the patient.

If there are circumstances that are preventing a patient from complying with the financial policy of Dakota Health Solutions, other arrangements must be made with our Billing Manager.

We want to thank you for your cooperation in supporting Dakota Health Solutions by promptly paying for services rendered.

If you have any questions, please do not hesitate to contact our office at (701) 365-0999.

Thank you.

I have read, understood, and agree to the above waiver.

Patient Signature ____ Date _____________

1383 21st Avenue North ▪ Fargo, ND 58102
P: 701.365.0999 ▪ F: 701.298.3738