OFFICE FINANCIAL POLICY

We welcome you and your family to our office. We take pride in providing quality chiropractic care for families. Please take time to review our Office Financial Policy, as these guidelines have been designed to better serve your individual needs.

PAYMENT POLICY:

- **Payment is due the day service is provided**.
- Our doctor participates in some insurance networks. There may be in-network or out-of-network coverage through your policy. Our staff will be happy to check with your insurance company to check out of network deductible but this is not a guarantee of coverage.
- Please communicate with the receptionist whether you will be filing claims to an insurance company and present your current insurance card to the receptionist for her to make a copy. If at any time you change insurance companies, please notify the receptionist immediately to update your records. All insurance claims are filed weekly.
- We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to directly assist your insurance company, adjustor or agent. Any denied or disputed claims will be treated as uncovered services.
- If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, payment in full is due; regardless of any claims submitted.

MY FINANCIAL RESPONSIBILITY

I understand that I am personally **financially responsible** for all services not covered by Insurance or by Medicare. I am also responsible for applicable annual deductibles or copayments.

CANCELLATION POLICY:

If for any reason you cannot make your pre-scheduled appointment time, we do ask for a 24-hour notice. If we do not hear from you to cancel your appointment at all or at least one hour before your pre-scheduled appointment more than three times an administrative fee of $60.00 will be charged to your account*. No further treatments will be administered until this fee is paid.

We are at a point in our clinic where we are extremely busy and need every available time slot for folks who are hurting and NEED care.

If you consistently miss your pre-scheduled appointments we can and will **dismiss** you from our practice. We will give you the names of other chiropractors within town to better suit your needs. We thank you for your understanding.

I have read and understand the Financial Office Policy and agree to abide by these terms.

x _____ _____

Patient's Signature or person acting on patient's behalf **Date**

Community Chiropractic
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