**Financial Policy**

**Scheduling:**

* All appointments during regular hours must be scheduled so as to reduce waiting time for you and others.
* You are free to stop in any time, however you will have to wait until all scheduled appointments are seen. You will be fit in as soon as possible.
* Cancellations require a 24-hour notice.

**Payment:**

* Payment is expected in full at the time services are rendered. This includes all co-payments.
* For your convenience we accept Cash, Checks, and most major Credit Cards.
* Payments on your deductible will be made by paying our per visit charge until it is met.
* Should you discontinue care for any reason other than discharge by the doctor, any outstanding balances will become immediately due and payable in full by you.

**Insurance:**

* Our office will verify your insurance coverage in an effort to help you determine exactly what chiropractic coverage is available under your policy.
* It is your responsibility to provide us with all the appropriate insurances forms, addresses, and information so that the proper filing can be submitted.
* We are not obligated to accept your insurance payment on assignment although for your convenience we may, based on our experience with your insurance carrier.
* You are always responsible for the portion of your bill that insurance may not cover and for your annual deductible.
* Remember that your insurance coverage is a contract between you, your employer, and your insurance company. We do not bill any secondary insurance carriers.

**Fees:**

* Our fees generally fall within what is considered reasonable and customary for this area.
* Many insurers pay a percentage of this reasonable and customary rate.

**Lastly:**

* You are responsible for all changes incurred as a patient of this office.
* We will do all we can with your insurance claims, however, you are ultimately responsible for payment.
* Past due statements for unpaid balances will be mailed. Statements unpaid for more than 30 days may be subject to an interest charge.

It is the goal of this office to provide you with the finest quality Chiropractic care available. If you have any questions regarding your health or any of our policies, please let us know. We would welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

I, the undersigned, have read and agree to the guidelines of the above stated financial, insurance and office policies.

Patient’s Signature: Date: