Chiro-Health, Inc - Financial Policy

Thank you for choosing our practice! We are committed to the success of your care and we hope you understand that payment of your bill is part of this care. Please read our policies bellow, ask us any questions you may have, and sign/initial in the space provided. A copy of this policy will be provided to you upon request.

1. **Insurance**. As a courtesy to our patients we will submit insurance claim ONCE AND ONLY at the time of your visit. If you **fail to provide us with current insurance information prior to your visit**, payment in full at our cash rate is expected at the time of service. _____(please initial).

2. **Co-payments, Co-insurance ,and Deductibles**. All co-payments must be paid at the time of service. You will also be responsible for paying any balance as per your insurance Explanation of Benefits (EOB) at the time we receive it. This balance will be charged automatically to your credit card on file _____ (please initial).

3. **Non covered services or not medically necessary services according to the insurance.** One hour massage, cupping, ART (Active Release Technique) and other non covered services must be paid in full at the time of visit. You may use your flexible spending account (FSA) for these non-covered medical related services. _____ (please initial)

6. **Patients without health insurance.** Payment in full is required at the time of your appointment. _____(please initial).

7. **Missed appointments.** Please understand that when you do not cancel an appointment you are unable to keep, it prevents other patients from receiving care they need. **Therefore, our policy is to charge $65 for missed appointments not cancelled within 48 business hours of the appointment time.** For example if you leave a message on Friday night or during national holiday to cancel an appointment for Monday or Tuesday morning, that is not considered a 48 business hour notice. I authorize Chiro-Health, Inc to charge my card on file $65 automatically on the day of the missed appointment. _____ (please initial)

8. Signatures. I confirm that I have read and understood the preceding information. Any questions that I may have had been answered fully and to my satisfaction. I am the patient, the patient's legal representative, or I am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

_____ _____

Signature of patient or responsible party Date

_____

Printed name