

OFFICE POLICIES

1. Please be on time for your appointment. Being late will cause severe scheduling disruptions, which can interfere with the quality of care you and other patients receive.
2. Cancellations of less than 24 hours will be billed to you at \$20.00 each.
3. Please do not wear strong perfumes or colognes. We see many patients with allergies or respiratory problems, and strong scents can impair their progress.
4. Continued cancellations or missed appointments may result in being release from care.
5. Children are welcome here as patients. If you bring children with you for your appointment you are responsible for their actions at all times.
6. We may schedule you for multiple appointments. This will help insure convenient appointment times for you, as well as provide you with the highest level of care possible.
7. If you need to spend extra time discussing your health concerns with the doctor, please let us know, so that we may schedule your next appointment accordingly.
8. Please notify the doctor of **ANY** changes in your health, regardless of the significance.

FINANCIAL POLICIES

1. Our office policy is that the patient is always responsible for the payment of their care. **Payment is expected at the time of service.**
2. We accept the following forms of payment: **Cash, personal checks, Visa / MasterCard.**
3. Please feel free to ask us any financial questions you may have. Our intention is to provide you with the highest level of service as well as care.

MEDICARE PATIENTS

1. Medicare will **ONLY** pay for Chiropractic adjustments. Patients will be responsible for any other charges not covered by Medicare or other insurance companies, at the time of service. Medicare co-pays, if not covered by secondary insurance, will also be collected at the time of service.
2. Medicare does not pay for the initial or follow-up examinations. Therefore, payment will be collected at the time of service.
3. Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to release daily chart notes, when necessary, for the processing of claims.
4. Any account where no payment has been received for ninety days will accrue interest at 1.0% compounded daily.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I UNDERSTAND THE POLICIES AS WRITTEN.

Patient or guardian: _____ Date: ____ / ____ / _____

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