Office & Financial Policies

Our goal is to provide and maintain a good doctor-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. ***It is your responsibility to read each section carefully.*** **If you have any questions, do not hesitate to ask a member of our staff.**

1) We value your time. If we are unable to see you within fifteen minutes of your scheduled appointment time, your visit is on us.
2) In turn, please value ours. If you are not able to keep an appointment, we require 24-hour notice. **For missed appointments, you will be charge for the full price of the visit**. This charge is your responsibility and we are not required to remind you of this charge. This amount cannot be billed to your insurance.
3) It is your responsibility to understand your plan benefits and coverage. We will do our best to assist you in understanding any unclear language in your insurance eligibility. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. **Co-payments are due at the time of service.**
4) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, **you will be responsible for full payment of the visit**. An itemized bill can be requested at that time for you to personally submit the charges to the correct plan for reimbursement.
5) If we do not participate in your insurance plan or you have insurance coverage but choose not to use it, waiving your rights to reimbursement by doing so, you will be considered a **Time-of-Service** patient and payment in full is expected from you at the time of your appointment.
   Time of Service Charges:
   $150 Initial Visit (21yrs +)
   $125 Reactivation Appointments (3yrs inactive for 21+, 1yr inactive for 50 yrs +)
   $40 Basic Adjustment
   $20 Additional for Decompression Table
   $5 Additional for Decompression Table for Clients
   $50 Initial Visit Child (Under 21)
   $25 Child Visit (Under 21)

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient or Responsible Party's Name_____

Responsible Party Member's Signature _____ **Date** _____

On completion, if requested, we will provide you with a copy for your records.