

Office Policy

We believe that a clear definition of our office policies will allow both you, the patient, and us the doctors, to concentrate on the big issue~
REGAINING AND MAINTAINING YOUR HEALTH.

APPOINTMENT POLICY

Multiple appointments can be scheduled, for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note it is the frequency of the visits that counts, and not the specific days. Therefore, if you are unable to keep an appointment for any reason, call immediately to reschedule your visit. It is your responsibility to make up any missed appointments within 7 days of cancellation. **This office reserves the right to charge \$20 for missed appointments and those appointments cancelled without a 24 hour notice.**

SIGNING IN

When entering the office on any given visit, please go directly to the front desk and "sign-in". We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment.

X-RAY POLICY

The x-rays that are taken are property of Chiropractic Health Associates. Release for purpose of review can be arranged at your request.

FEES CHARGED

All fees are based upon individual services rendered, not results achieved, and may vary from visit to visit depending upon doctor specific recommendations. A complete list is available at the front desk.

INSURANCE OPTION (INCLUDING MEDICARE)

In order for us to bill insurance for your service, we must obtain a copy of your insurance card. We will call to verify benefits, but verification is not a guarantee of payment. **All deductibles, Co-Pays and Co-insurance are due at the time service is rendered.** We will not bill for said items.

WORK COMP & PI

Our office does accept work comp and personal injury cases. However, it is not considered work comp or personal injury until we have all insurance information, a claim number on file, and liability is accepted.

OTHER

It is our policy that all services rendered in the office are charged directly to you, the patient, and that you are responsible for all services, including those not reimbursed by third party payors. **All payments are expected at the time of service, or at the end of each week.** Patients balances may not exceed \$200.00 at any time.

There is a \$30 NSF fee charge on all returned checks. All accounts not paid in 90 days will be turned over to collection. Any financial arrangements are to be determined prior to services rendered

By signing below I acknowledge that I have read, understand and agree to the terms of the office and financial policies of Chiropractic Health Associates.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____