***Financial Policy as of August 11, 2015***

**Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.**

**All patients must complete our Symptom Survey form before seeing the doctor.**

***FULL PAYMENT IS DUE AT THE TIME OF SERVICE.***

***WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER/AMEX.***

**Regarding Health Insurance**

**If requested, we will file your claims with your primary and/or secondary insurance company. Alternatively, we will provide you with the paperwork necessary to file an insurance claim. We can also provide assistance if your insurance company requests additional information (such as medical records) from you. If reimbursement is sent to our office, a check from Abundant Life Chiropractic will be issued or a credit will be applied to your account for future services. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under medical insurance.**

**Durable Goods, and Nutritional Supplements**

**Payment in full is expected at the time the durable goods, or nutritional supplements are purchased.**

**Usual and Customary rates**

**Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.**

**Adult and Minor Patients**

**Adult patients are responsible for full payment at time of service. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.**

**Checks**

**A $35.00 fee will be assessed for any check returned to this office from our bank.**

**Missed or cancelled appointments**

**A $25.00 fee will be assessed for appointments that are missed or are not cancelled 24 hours in advance.**

**Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.**

**I have read the Financial Policy. I understand and agree to this Financial Policy.**

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**Signature of Patient or Responsible Party Date**