

**Patient Financial Policy**

Your understanding of our financial policies is an essential element of your care and treatment. We are committed to providing you with the best chiropractic care possible and have established our Financial Policies to achieve that goal. If you have any questions, please discuss them with our front office team or manager. In accepting care, you agree to the following:

	Fee Schedule
Consultation í í í í í í í í í í í .N/C	Cold Laser Session.....\$30.00
Initial Examí í í í í í í í í í í í . \$52.00-\$144.10	Cold Laser Package of 6 .....\$150.00
Dynamic Examí í í í í í í í í í í í \$53.50-\$98.60	Monthly Wellness/Corrective Adjustment Plans.....\$100.00- \$500.00
X-Rays (per view)í í í í í í í í í í í \$28.33-\$33.00	Intersegmental Traction.....í .....\$22.55
Chiropractic Adjustment(s)í í í í í í í ..\$50.00-\$55.00	Electronic Muscle Stimulationí í í í í í í í \$33.00

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, or check. I acknowledge responsibility for my account and guarantee payment of all charges against the account.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- I understand that this chiropractic office will assist me with any information, necessary reports or forms needed for me to personally file for reimbursement from my carrier.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to this office.
- There is a service fee of \$35.00 for all returned checks. Your insurance company does not cover this fee.
- I authorize ACT Wellness Center to release necessary information to my insurance carrier.
- I authorize ACT Wellness Center to accept assignment of benefit.

I understand that my Payer may not pay for all of my care, even services that the Office deems medically necessary. I agree that I will be responsible for verifying and understanding my own coverage and benefits. Right now, it appears that the following items or services may not be covered. I understand that there may be other items or services that are not covered and that if I have any questions, I will contact my Payer for more details. I agree that I am personally and fully responsible for all services rendered by the Office, including care which my Payer may determine is not medically necessary.

**Signature of Patient/Responsible Party:** \_\_\_\_\_  
 Printed Name of Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_  
 Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Printed Name of Witness: \_\_\_\_\_  
 \_\_\_\_\_ Patient initials to indicate copy received.