Office Policy: Please initial each line.

_____ **Missed appointments** are subject to a fee of $**45.00**. You must **cancel 5 hours** in advance to avoid this fee. This fee is not payable by your insurance company and is the sole responsibility of the patient. Canceling or "no showing" causes a loss of this time, which could have been used to see other patients.

_____ **Co-Payments -** By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service & we subsequently send you a statement, an administrative fee of $5.00 will be added to your account for repeat billing.

_____ Our office is pleased to accept your insurance assignment AFTER your deductible has been satisfied. When your exact coverage is verified by the responsible party, we will file your claim and assist you in every way we can. **However, it must be fully understood that the contract is between you and your insurance co. and that you are fully responsible for any services not covered by your insurance.**

_____ In the event that my account becomes delinquent for more than 90 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all collection costs **not to exceed 50%,** as well as court costs, attorney fees & interest fees accrued with the collection of this account.

_____ As a courtesy to our patient we will verify your insurance coverage. Verification of benefits is not a guarantee of payment. Payment will be determined by the insurance company at the time the claim is received. **You are responsible to know your deductible, co-pay, and if a referral is needed.**

_____ **Rescheduling Appointments**
We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time on the same day. If the same day is not possible, be sure to make up the missed appointment in that week.

_____ Our office will **NOT** enter into a dispute with your insurance company for a denial on claims if the denial was due to your negligence. Ex. Policy terminated, premium not paid.

_____ Patients whose treatment schedule is of once a month might not be eligible for insurance assignment, if your insurance requires authorization. The Insurance Company will not pay for what they may view as maintenance care. This only applies to Insurance companies that require authorization.

I have read the above information. I understand and agree will all of the above office policies.

Patient's Signature _____ Date_____