

FINANCIAL POLICY

Our primary responsibility is to help you, our patients, experience good health and we want to spend our time and energy toward that goal. Therefore, we would like to clarify the following points regarding our payment policy to avoid any misunderstandings.

We have a variety of payment plans that are designed to make care an affordable part of your family budget. Please talk with our Accounts Manager if you have any questions.

1. We will bill your insurance carrier if our Business Office determines that you have chiropractic coverage. Please remember your insurance is a contract between you and your carrier. Co-pays are due at the time of each visit.
2. All accounts are due and payable at the time of your visit unless satisfactory arrangements have been made with our Accounts Manager.
3. Any balance on your account over 60 days will accrue a \$5.00 Rebilling fee.
4. Our office requires **4 hours notice** for canceling a chiropractic appointment and **24 hour notice** for massage appointment. Our missed appointment fee is \$25.00,

By signing this form, you are agreeing to comply with all the policies on this page:

- ◆ I have read and understood the above Financial Policy.
- ◆ I hereby assign payment from my insurance company directly to *IMPAC* Health.
- ◆ I hereby authorize *IMPAC* Health to release to my insurance carrier any medical information necessary in the processing of my claims for services at their request.
- ◆ I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures.
- ◆ I certify that I am not presently enrolled in any HMO (Health Maintenance Organization and subsequent rejection of a claim due to such enrollment will constitute responsibility for payment of claim on my part.

Print your Name: _____ **Date:** _____

Signature: _____

Name and phone number of family or friend not living with you

_____.