Office Policies

Thank you for selecting our office to provide chiropractic care to you and your family members. Please note the following office policies:

- **We do not directly work with any insurance companies.** However, if you wish, we can provide you with a superbill that has your diagnoses and charges that you can submit to your insurance company for direct reimbursement *based on your coverage.* **We do not handle personal injury cases in relation to auto accidents**. Medicare patients **cannot** be seen in our office at this time.

- **Payment is required at the time of service** or at the time of purchase of any products. Payments can be made by cash, check, Visa, MasterCard, and Discover. We do not accept American Express.

- **Unpaid balances of 30 days or more will accumulate a $30 late fee and an additional $30 late fee at 60 days** unless arrangements have been previously discussed. Unpaid balances beyond 60 days will be passed to collections. *I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.*

- **A $30 fee will be applied to your account for any checks that bounce.** This fee must be paid prior to continuing with care.

- **In order to maintain active status, patients must be seen at least once within a 6 month period.** If it has been over 6 months since the last adjustment, we require a re-evaluation (an additional $50). If it has been over a year since the last adjustment, we require a full new patient examination (an additional $70).

- **We have a no show/no call cancellation policy.** In the event that you cannot make your appointment, we ask that you please give us a call to let us know so we can schedule other patients during that time. Failure to do so will result in a **$25 no show/no call cancellation fee**. We request a 24 hours' notice if you are unable to make your scheduled appointment.

I have read and understand the policies stated above:

____ _______________________

Patient (Parent) Signature Date

____

Print Patient Name