

Dixon Center for Integrated Health Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. By informing you in advance of our financial policy it allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have any questions please do not hesitate to ask a member of our staff.

Appointments:

1. We value the time we have set aside to see and treat you. If you are not able to keep a chiropractic appointment we would appreciate notice as soon as possible.
2. If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3. We require 24 hour notice for cancelling massage, acupuncture, or weight loss appointments. A 50% fee will be charged for these missed appointments.

Initial: _____

Insurance Plans:

Please understand

1. It is your responsibility to keep our office updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2. It is your responsibility to understand your benefit plan with regard to, for instance:
 - a. If a written referral or authorization is required to see specialists or if preauthorization is required prior to a procedure.
 - b. Some charges may or may not be covered. While the filing of insurance claims is a courtesy that we extend to our patients, not all plans cover all services performed in a chiropractic/medical office. All charges not covered by your plan are your responsibility.

Initial: _____

Financial Responsibility:

1. Payment is required at the time of service. We accept cash, check, or credit card (Visa or MasterCard).
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. Financing is available with Care Credit for those who qualify.
4. If we do not participate with your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5. Self-pay patients must pay at the time of service in full. Standard rates will apply unless the patient enrolls with the discount medical plan organization (ChiroHealth USA) which legally entitles patients to cash discounts.
6. General benefit verification will be provided on the second visit as a courtesy to patients, however **this is not a guarantee of payment** and *final determination will be applied off the explanation of benefits.*
7. For scheduled appointments, prior balances must be paid prior to the visit.
8. Bills unpaid for more than 90 days may be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may incur additional fees.
9. There is a service charge of \$20 for returned checks.
10. Please call or email if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.
11. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent you from receiving care you need.
12. Refunds are only provided after all outstanding claims have been processed by the insurance company for services rendered and after patient liability has been accounted for. If a true credit remains after this point, the patient is entitled to have their credit returned within 5 days via check or keep it on file to go towards future visits.
13. ***If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our business office staff.***

Initial: _____

Medical Records/X-rays:

1. Advance notice is required for x-ray requests. Typically 3-5 business days. For duplicate copies of x-rays – the cost is \$20 per film to the patient. Original copies of x-rays may be signed out but must be returned no later than 5 business days.
2. If you transfer to another physician, we will provide a copy of your medical record, free of charge, as a courtesy to you. We need 48 hours' notice.
3. A copy of your complete record is available for a \$1.00 per page.

Initial: _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name _____

Authorized Representative _____ **Relationship** _____

Signature _____ **Date:** _____

Witness: _____ **Date:** _____