Excellence in Health Chiropractic & Rehab Clinic
William A Ross D. C.

FINANCIAL POLICY

Thank you for choosing Excellence in Health Chiropractic & Rehab Clinic. It is our commitment to make your chiropractic and physical therapy needs a success. To better serve your financial needs, our office offers several methods of payment. Please choose the plan that suits you. Patients who are here for their first visit are expected to pay in full unless prior arrangements have been made with the billing department. We are happy to answer any questions you have regarding our fees.

Please check one of the following plans:

_____ **Cash/Check/Credit Card***: Fees are to be paid at the time services are rendered unless special arrangements have been made in advance.

_____ **Workers' Compensation***: We will bill your employer's workers' compensation insurance company directly. We require all insurance information, including claim number, within 3 days after your first appointment.

_____ **Auto Accident***: We are willing to work with your lawyer or bill the insurance company directly. You will need to provide all claim numbers and billing information within 3 days after your first appointment.

_____ **Private Insurance***: As a courtesy to our patients, we will bill your insurance company once you have met your annual deductible. You are responsible for **co-payments** and for any **non-covered services** at the time of your visit.

- A 12% per annum will be applied to unpaid balances that are over 90 days.

Cancellation Policy

Appointments can be re-scheduled or cancelled free of charge if we are notified at least 12 hours before your scheduled appointment. Cancellations or missed appointments will be subject to a $20 administrative fee if the 12 hour notice was not given. Cancelled or missed massage therapy appointments will be subject to a $20 cancellation fee for 30 minute massages, $30 cancellation fee for 45 minute massages, and $40 cancellation fee for 60 minute massages. Insurance will not be billed for this charge.

Financial Agreement

* I agree to pay promptly all fees and charges for treatments provided to me and/or my family.
* I have read the policies above and understand them.
* I understand I am financially responsible for all charges, whether or not they are covered by my insurance company.
* I authorize this clinic to release to my insurance carrier any medical information needed to obtain payment for services rendered.
* I authorize and request payment of medical benefits directly to my provider.
* I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
* I understand that charges may occasionally be added or modified by my clinician.
* I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date. Should legal action be taken by this office to collect an unpaid balance due for medical services provided, I/we agree to pay reasonable attorney's fees or other such cost as the Court determines proper.

**A photocopy of this Assignment shall be considered as effective and valid as the original.*

I understand and agree to this Financial & Cancellation Policy:

Patient Signature :_____ Date_____

Guarantor Signature _____ Date_____