GENERAL

1. A 24 hour advanced notice is required if you are not able to be present for a scheduled appointment. If a 24 hour advanced notice is not given when you miss, cancel or reschedule an appointment, a missed appointment fee of $35.00 will automatically be charged to your account.
2. It is important to be punctual for your appointments. If you are late for an appointment and there is not sufficient time, you will not receive treatment and a missed appointment fee of $35.00 will automatically be charged to your account.
3. An additional fee of $35.00 will automatically be charged to your account for emergency treatments provided to you outside of office hours.

CASH PATIENTS

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff. Payment for all services provided will be required at the time services are rendered for cash patients, or until your insurance coverage can be verified.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE PATIENTS

1. If you have insurance we gladly accept assignment, provided we have prior certification from your insurance company. Some exceptions apply and you will be notified if any exceptions apply to you.
2. Once your insurance coverage has been verified, payment for all services rendered to you within a weeks time will be required on your last visit each week.
3. We accept assignment of your insurance coverage as a courtesy to you. You are responsible for your entire bill should your insurance not make payment for any charges on your account or for any service provided you for any reason. We are not a mediator between you and your insurance company and we will not enter into any dispute with same, as your contract is between you and your insurance company.
4. If Heartland Clinic of Chiropractic accepts assignment of benefits, we require that payment be sent directly to our clinic. By signing this Office Financial Policy you are authorizing payment to be sent directly to Heartland Clinic of Chiropractic and agreeing that if you should receive a check from your insurance by mistake for services provided here, you are required to bring it into the office upon receipt. All insurance payments, regardless of which company issues a check first, are applied to your account as long as a balance is due. If an overpayment exists on your account after all insurance billings have been processed, an overpayment check will be issued from us, not your insurance company.
5. We may request that you bring to our office any worksheet or explanation of payments that your insurance company provides you so that we may determine if proper payment has been made.
6. We accept assignment for the initial care plan only. Any follow-up visits are payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we require full payment per visit.
7. Any services not covered or coverage reductions by your insurance are your responsibility.
8. This office will resubmit a claim **ONE TIME**. We will not enter into any dispute with your insurance company. If coverage problems arise, you are expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied services will be treated as uncovered services and you responsible to pay such charges on a timely basis.
9. If you are referred to another specialist or discontinue care for any reason other than discharge by the doctor, your bill is due in full immediately; regardless of any pending claims submitted to your insurance company. If any overpayment exists after all insurance bills have been processed, we will issue you an overpayment check.
10. If you have any questions concerning this or any other matter, please speak with the receptionist prior to seeing the Doctor.

It is understood this care is highly specialized, unique, and an effective method of care. (Knowing that 70% of the Doctor's knowledge, expertise, time, and technical equipment will be utilized in the first three weeks of patients care, 20% in the second phase, and 10% in the final phases of care.)

I _____,(print name) have read and understand the Office Financial Policy and agree to abide by these terms.

_____ _____

(patient/guardian signature) (date)

_____ _____

(witness signature) (date)