Payment Policy

There are two acceptable forms of payment upon completion of services:

CASH: Payment required at the end of each office visit.

OR

INSURANCE ASSIGNMENT: You are responsible for your co-pay at EACH office visit. Insurance reimbursement is signed over to our clinic.

Insurance Assignment

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and a wellness health care program may be recommended. We will notify you of this change.
2. It is your responsibility to pay all deductible amounts. You must stay current with your percentage of responsibility or co-payment. This must be paid at the end of each office visit. Prepayments may also be made. In certain individual circumstances, if payment at time of service is not possible we can work with the patient to create a reasonable payment plan.
3. Insurance carriers are billed on specific 7 day cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed.
4. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the clinic. Failure to do so may result in collection action.
5. If you discontinue your care for any reason, you will be responsible for any unpaid balance remaining.
6. This clinic cannot guarantee an insurance provider will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all charges and pursue reimbursement from the insurance company on his/her own.
7. Any bank fee incurred from returned or bounced personal checks will be the patient's responsibility. We reserve the right to add an additional fee of $50 for any returned or bounced checks.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions as specified above.

_____	_____	_____
Signature	Social Security #	Date