Family Chiropractic & Wellness Center

FEE FOR SERVICE AGREEMENT

I agree to pay for services I receive, either at the time of service or by scheduled financial arrangement.

I agree to the appointment schedule set forth by my doctor. If ever I am unable to keep a scheduled appointment, I agree to call at least 30 minutes prior to the appointment time to reschedule. If I miss an appointment without giving 30 minutes notice, I will be responsible for a $20 missed appointment fee. This fee is not reimbursable by insurance or third party payers. I further agree to make up any missed appointments within one week.

I understand that my Doctor will do a re-examination approximately every 12 visits in order to assess my progress and make any necessary changes in my care program. I am responsible for paying for these re-examinations as per my payment agreement.

I understand that this office only bills insurance for those patients with Medicare benefits. Otherwise, I am solely responsible for submitting claims for services I receive, if I so choose, as well as follow-up of those claims. The office will happily provide me with the appropriate information for billing. I am responsible for obtaining the claim forms from my insurance company, and I should request that my insurance send payment to me directly.

I understand that this Agreement is not a guarantee of results and deals solely with the services to be rendered and the fees to be paid for the care I receive. My payment obligation is not contingent upon the outcome of care.

_____ _____

Signature of Responsible Party (Patient, Parent, Guardian) Date

Patient's name if other than responsible party: _____

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