Late Arrival & Missed Appointments: I hereby acknowledge that I will be charged a fee of **$100** for a late or missed appointment. An appointment is considered late if the patient arrives more than 15 minutes after the scheduled visit time. **A missed appointment charge occurs when the patient fails to notify this office of cancellation/rescheduling at least 48 hours prior to the scheduled visit.** If you need to reschedule your appointment for any reason, you must call this office directly. ***Your credit card on file will be charged in this instance.***

Patient Financial Responsibility: I understand that although I may have assigned insurance benefits to this office (for chiropractic services only) it is likely and probable that my insurance coverage will be less than the amount billed (due to copay, co-insurance, and/or deductible). I acknowledge that it is my responsibility to pay the balance of my bill once insurance benefits have been received. I also will be responsible for any charges refused or discounted by my insurance company. Further I will pay for any collections or legal charges incurred in the collection of these uncovered charges should I fail to pay them during the agreed upon time.

Payment of Services: Payment in full is expected at the time of services. The Center receives payment in cash, check, credit and debit form, and any insurance that will accept us for chiropractic services.

Returned Checks: A standard fee of $25.00 will be charged for any returned checks.

I have read and understand the Center's policies and agree to them.

Print Name: ____

Signature: ____ Date: ______________