Alpine Chiropractic Center
Patient Policies

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our policies, which we require you to read and sign prior to treatment. To better serve your financial needs, our office offers several methods of payment. We are happy to answer any questions you have regarding our fees.

Please initial one of the following:

______**Cash/Check/Visa/Mastercard*:** Fees are to be paid at the time services are rendered unless special arrangements have been made in advance. We do offer a time of service discount to our patients who choose to pay in full at the time of their visit. If you choose to accept this discount, no insurance coordination or submittal will be provided by our office. *This discount requires that the payment be made on the same day as you are treated. Any service that is not paid for on the day of service is ineligible for this discount.*

_____**Private Insurance*:** As a courtesy to our patients, we accept assignment of insurance benefits after deductibles (if applicable) are met. Co-payments are due at time of service. We cannot bill your insurance company unless you provide your insurance information. Please be aware that some, and perhaps all, of the service provided may be non-covered charges or considered by your insurance company to be not medically necessary.

_____**Workers' Compensation*:** We will bill your employer's workers' compensation insurance company directly. You will need to provide all claim numbers and billing information within 3 days after your first appointment.

_____**Auto Accident*:** We will bill YOUR insurance company directly. You will need to provide all the claim numbers and billing information within 3 days after your first appointment. **WE DO NOT DO THIRD PARTY BILLING**.

Massage Policy

Please be considerate. We value our patients' time. Please make a reasonable effort to give us at least 24 hour notice if you must cancel or re-schedule. ***If you do not show up for your scheduled appointment, you will be subject to a $75 cancellation fee. Please note that this fee cannot be billed to insurance companies and must be paid by you personally***. After your 10th massage, you will need a mandatory re-exam with your doctor in order for us to continue billing your insurance.

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

By signing below I state that I understand and hereby agree to abide by these policies.
Signature:____ Date:______________