

TOTAL BODY WELLNESS

Financial Policy

We are committed to providing you with the best chiropractic care possible. We have established our financial policies to achieve this goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless other arrangements are made in advance.

- Health Insurance:** As a courtesy to you, we will file your health insurance, however we cannot render services on the assumption that our charges will be paid by an insurance company. Therefore, all services are charged directly to the patient and he or she remains personally responsible for payment. We will gladly verify your coverage and provide you with an estimate of how your insurance will support you. This estimate is provided based on the benefits provided by your insurance company. All insurance benefits will be assigned to the doctor where applicable. As your insurance policy is a contract between you and your insurance company, it is your responsibility for collection of these benefits. If the insurance company does not pay within 45 days after the services are rendered, you will be responsible for the balance and contacting your insurance company regarding settlement. For identification purposes and so we can file your insurance for you, we ask that you provide us with your insurance card and a drivers license. A copy will be kept in your file.
- Cash Patients:** All fees are payable at the time services are rendered. There is no charge for a consultation in our office and all fees will be discussed with you before charges are incurred.
- Methods of Payments:** For your convenience we accept Cash, Personal Checks or Credit Cards (Visa, MasterCard, Discover, Amex). All checks returned as insufficient funds will incur a \$35 returned check fee.

I authorize Total Body Wellness to furnish information concerning my present health complaint to the insurance company for the purposes of collecting insurance benefits for charges incurred. I direct the insurer to pay said benefits directly to Total Body Wellness (Jaelyn Ent., PA). I have read and understand the above policies.

Patient Signature (Parent or Legal Guardian) _____ Date: _____