

# Scarborough Family Chiropractic

## Financial Policy

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The purpose of this form is to clarify your financial responsibilities so we can devote our efforts to helping you.

### **FEES**

#### Examinations

New patient \$175.00

Re-examination \$70

X-Rays \$130.00

Adjustments \$50

Massage Therapy \$25 per 15 min unit (Discount may apply)

(This does not include any additional services that may be billed to your insurance beyond adjustments and exams.)

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### **FORMS OF PAYMENT**

Patients are responsible for full payment at the time of service, unless prior arrangements have been made. We accept cash, personal check, Visa, and MasterCard. There will be a \$20 service charge on all returned checks.

### **BILLING**

We do not bill patients. Our policy is that a patient not have a personal cash balance. If special arrangements are made and a patient develops a balance, once over by 30 days interest charges of 1.5% per month will begin to accrue plus service fees and any legal or collection fees.

### **INSURANCE**

All professional services rendered are the responsibility of the patient. We will file your insurance claims as a courtesy to you, although you, not the insurance company, are responsible for all charges incurred. We will do our best within our legal limits to support your covered services, however your health insurance is an agreement between you and your insurance carrier, therefore it is your responsibility to handle any disputes with your insurance company that is beyond our capability.

### **AUTHORIZATION**

I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

### **CANCELLATION POLICY**

All Massage appointments require a **24 hour notice of cancellation.** Less than 24 hours the patient's account will be billed for the fee of the session.

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Patient/Responsible Party

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Office Rep/Witness