Crafted Care Chiropractic
A walk-in practice that is here for you!

Office and Financial Policies

Thank you for choosing Crafted Care Chiropractic for your healthcare needs. We are committed to providing you with the highest quality care. Every patient must be thoroughly informed of their treatment options and the financial obligations for a particular service. Please carefully read and then sign this form to acknowledge your understanding of your financial obligations related to your treatment. If you should have any questions regarding our financial policies, please ask our front desk or insurance personnel before signing this document.

MONTHLY STATEMENT

If you have a balance on your account, we will send you a monthly statement. Please make sure to pay any balances before they are over 30 days, after which they will be considered past due, and a $5.00 service charge will be added.

PAYMENT OPTIONS IF YOU HAVE NO INSURANCE

1. Payment is due at the time of service unless other arrangements are made.
2. Payment options are available such as cash, check, debit card, credit card, HSA, FSA, or Care Credit. A Service fee of $1.00 applies to credit card transactions.
3. For all products payment is due at the time of purchase.

INSURANCE At the time of service, you must present your insurance card. We will bill your insurance as a courtesy to you. Insurance is a contract between you and your insurance company. We are a party to this contract. Although we may estimate what your insurance company will pay, it is the insurance company that makes the final determination of your coverage. You agree to pay any portion of the charges not covered by insurance, including deductibles, co-payments, and any services rejected by your insurance company. If your insurance company continuously denies payment of a claim, it will become your responsibility to contact them.

All copays, deductibles, and non-covered services will be collected at the time of services.

INITIALS_____

RETURNED CHECKS There is currently a $40.00 fee for any checks returned by the bank for non-sufficient funds.

NON-PAYMENT If your account is over 90 days past due, you will receive a letter regarding your delinquent account. Please be aware that if a balance remains unpaid, we may forward your account to our attorney for collection.

COLLECTION FEES In the event your account is placed in collection status, any fees incurred due to this will be added to your outstanding balance. These charges will be your responsibility and billed directly to you.

MASSAGE APPOINTMENTS

- Our policy requires at least a 4-hour notice if you are canceling or rescheduling your massage appointment.
- A fee equal to half of the price for the time scheduled will be charged for missed appointments.
- This fee is not covered by insurance.
- These charges will be your responsibility and billed directly to you.

DIVORCE In case of divorce or separation, the party responsible for the account would be the parent authorizing treatment for the child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

INITIALS_____

PAPERWORK We are happy to fill out papers that are directly related to time off work due to an injury or illness for your place of employment at no charge. Paperwork that is done for loan payments or insurance policies that reimburse the patient is done for a fee of $30.00. There is also a three-day notice requirement for all paperwork and insurance forms.

EMERGENCY CALLS Emergency visits, after-hour visits, or weekend visits will be charged a fee of $100.00.

TREATMENT OF MINOR A parent must be present on the initial visit for a child under 18 to be treated. As the consenting adult, you agree to assume all financial responsibilities for treatment. We strongly encourage you to be available for future appointments in order to be advised on procedures and charges that will be involved.

FAMILY PLAN For those who do not have insurance coverage or who have reached their maximum policy limits, we offer a variety of affordable payment options that will allow your entire family to receive chiropractic care. Please inquire about affordable wellness care.

I authorize payments to be made directly to Crafted Care Chiropractic and fully understand that I am the responsible party for all charges incurred by me and my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims. I have read and understand the "Office and Financial Policies". By signing below, I hereby authorize the assignment of financial benefits directly to Crafted Care Chiropractic for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Policy.

Patient's Name (Printed): _____ Date: _____

Patient's Signature: _____ Date: _____

To be completed by the patient's representative, if necessary. E.g. If the patient is a minor or is physically or otherwise legally incapacitated:

Signature of Patient's Representative: _____ Date: _____

Printed Name of Patient's Representative: _____ Date: _____

Relationship to Patient: _____