Anderson Chiropractic
Office Policy

Appointments Please be on time for your appointment. While we will accommodate walk-ins, we prefer our patients to schedule an appointment to minimize waiting. If you are unable to keep a scheduled appointment, we ask that you notify us as soon as possible. Habitual cancellations or missed appointments may result in a cancellation fee.

Appointment Reminders/Communication We may use your name, address and/or phone number to provide you with appointment reminders and correspondence (such as voicemail, text messages, postcards, or letters).

Payment The responsible party [patient/guardian] is accountable for payment of their care. We accept the following forms of payment: Cash, check, credit card. Payment is expected at the time of visit. Should you require a payment arrangement, please talk with our Front Office.

Auto Accident/Workers Compensation It is your responsibility to provide all necessary information so that we may file with the responsible party. By signing this form, you are aware that upon any denial/non-payment, you are obligated to Anderson Chiropractic for payment of services rendered. If legal representation is involved, and direct payment is not made to this office, you are responsible for any balance on your account. Likewise, if legal representation is involved, payment must be made in a timely manner to this office, regardless of legal proceedings pursued by the patient/guardian.

Past Due Accounts Any account whereby no payment, or payment arrangements have not been agreed to [in writing] by Anderson Chiropractic, for ninety days, may be sent to a third-party collection agency/legal action. Collection/legal fees will be the responsibility of the responsible party. Returned checks or rejected credit card payments will be charged a $35 service fee per occurrence.

Cash Plan We do offer a CASH price. Please inquire at the Front Office.

Insurance It is the responsibility of the patient/guardian to provide their current insurance information at the time of the visit. Insurance coverage is not a guarantee of benefits. An insurance contract is between the patient/guardian and the insurance company. Our office will do due diligence to make sure we have submitted your claim(s) appropriately. Our office is not able to guarantee benefits and is not responsible for the processing of the claim(s) received by your insurance carrier.

Divorce/Legal Separation In case of divorce or legal separation, the party responsible for the account would be the parent/guardian authorizing treatment for the [dependent] child. If the divorce decree/separation agreement 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.

Treatment of Minor A parent/guardian must be present on the initial visit for a child under 18 to be treated. As consenting adult, you agree to assume all financial responsibilities and liability for treatment of said minor. We strongly encourage you to be available for future appointments to be advised of all procedures and charges that will be incurred. A *Consent to Treat Minor Form* must be signed by the parent/guardian prior to the minor receiving treatment.

Family Plan For those who do not have insurance coverage, have an HSA account or who have reached their maximum policy limits, or have a high deductible plan -- we offer an affordable payment option that will allow your entire family to receive chiropractic care. This option is not submitted to insurance. Please inquire at the Front Desk.

X-Rays Images taken by Dr. Susan A. Anderson, D.C., are the property of Anderson Chiropractic. If you need a copy of your X-ray(s), an *Authorization to Release Information* must be signed. Please ask the Front Desk.

Assignment of Benefits Your signature below designates assignment to this office for collection of insurance benefits and authorizes this office to provide the necessary medical documentation for claims processing to said insurance.

Liability Waiver I release and hold harmless Anderson Chiropractic and their employees from any liability for any loss, damage, injury or expense that I may suffer as a result of my chiropractic visit(s) including, but not limited to, accidents, acts of God, war, civil unrest, sickness, transportation, scheduling, government restrictions or regulations, any and all expenses which I may incur while participating in the chiropractic visit(s). In the event one or more of the provisions of this waiver is deemed to be invalid, illegal, or unenforceable in any respect under applicable law; the validity, legality, and enforceability of the remaining provisions hereof shall not in any way be impaired thereby. This waiver is effective while I am a patient and participating in chiropractic care. I understand that this agreement cannot be modified or interpreted except in writing by Anderson Chiropractic [Dr. Susan A. Anderson, D.C.] and that no oral modification or interpretation shall be valid. I have read this document carefully and acknowledge my responsibility and the effect of this liability waiver.

Consent I hereby authorize Anderson Chiropractic [Dr. Susan A. Anderson, D.C.] to examine, diagnose and treat my condition(s) as deemed appropriate and within the scope of care. I give authority for the recommended procedure(s) to be performed.

Patient Signature _____ **Date** _____

If applicable, Guardian _____**Date** _____

Guardian's printed name _____**Relationship to patient**_____

Patient phone number _____ **Phone carrier**_____