THE CHIROPRACTIC PLACE
Feel Better, Stay Better

7051 Cypress Terrace, Suite 106
Fort Myers, FL 33907
(239) 887-3066

Financial Policy

The following is a statement of our financial policy which we require you to read, agree to, and sign prior to any treatment. In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.
WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMEX, DISCOVER, AND CARECREDIT.

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual or advertised discount under the following circumstances:

- You are covered by a State or Federal program with a mandated fee schedule (MEDICARE).
- If this office advertises a coupon or special discount for services. (However, by law, these discounts cannot be extended to active Medicare patients when Medicare is being billed for reimbursement.)

Regarding Insurance:

- We will provide you with a detailed receipt that you may submit to your insurance company for reimbursement. We are not a participating provider in any insurance program other than Medicare and while you may have coverage for Chiropractic services, we do not submit claims to any third parties for reimbursement other than Medicare.
- We participate as a NON-PARTICIPATING ("Non-Par") Medicare Provider, which means we do not receive payments directly from Medicare. Therefore, payment in full is due at the time of service. Claims submission is done weekly, provided we have all data to file the claim.
- Payments must be made in full each visit unless other arrangements or a payment plan secured with a credit card on file is arranged in advance.

Minors: The adult accompanying a minor (parent or guardian) is responsible for full payment. Unaccompanied minors will not be treated.

Usual and Customary Rate: Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary to our area.

Cancellation Policy & Additional Fees: We have a 24-hour cancellation policy; there will be a fee assessed for appointments missed without 24 hours prior cancellation that is equal to the fee of the scheduled service. There is a 1.5% monthly late charge assessed on all balances after 30 days past due on payment plans. Additionally, the undersigned agrees to pay a collection fee of 35% of the total owed when sent to collection, and all attorney fees and court costs incurred by the creditor.

_____ **(Initial) I understand additional fees may assessed if I fail to give 24hr notice for cancellations.**

I have read, understand, and agree to the above financial policy (signature):

Patient (or Responsible Party) _____ **Date** _____