POLICY'S FOR CUMBERLAND VALLEY CHIROPRACTIC & WELLNESS (CVCW)

MISSED APPOINTMENTS

- NO CALL, NO SHOW CONSTITUTES A MISSED APPOINTMENT. MINIMUM ONE HOUR CANCELLATION NOTICE IS REQUIRED.
- YOU WILL BE CHARGED $25.00. CARE WILL NOT BE CONTINUED UNTIL THE BALANCE IS PAID IN FULL.
- REPEATED MISSED APPOINTMENTS WITHOUT NOTIFICATION MAY CAUSE YOU TO BE DISCHARGED FROM THE PRACTICE.

FINANCIAL POLICY

- YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ACCEPT ASSIGNMENT FROM MANY INSURANCE COMPANIES. IN THE EVENT THAT WE DO NOT ACCEPT ASSIGNMENT OF BENEFITS, YOU WILL BE RESPONSIBLE FOR PAYMENT.
- YOUR INSURANCE COMPANY HAS FINAL DETERMINATION OF PAYMENT. YOU WILL BE BILLED FOR ALL CO PAYS, COINSURANCES, DEUCTIBLES AND MEMBER/PATIENT LIABILITIES.
- CVCW WILL VERIFY YOUR BENEFITS BUT THIS IS NEVER A GUARANTEE OF PAYMENT. I AM RESPONSIBLE FOR PAYMENT IF MY INSURANCE DOES NOT PAY.
- IT IS YOUR RESPONSIBILITIY TO UPDATE YOUR INSURANCE WITH OUR PRACTICE.
- I AUTHORIZE THE DOCTOR TO RELEASE ANY INFORMATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYERS, MY HEALTH INSURANCE, AND MY ATTORNEY.
- I AUTHORIZE MY INSURANCE PLAN TO MAKE DIRECT PAYMENT OF MEDICAL BENEFITS TO CVCW.
- ALL CO PAYS, COINSURANCES, DEUCTIBLES, AND WELLNESS FEES ARE DUE AT THE TIME OF SERVICE.
- WE ACCEPT CASH, CHECK, MASTERCARD, DISCOVER, AND VISA. A BANK SERVICE FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.
- IF YOUR ACCOUNT SHOULD BECOME DELINQUENT PAST 90 DAYS, WE WILL USE A COLLECTIONS AGENCY TO COLLECT ON YOUR ACCOUNT. ANY AND ALL CORRESPONDENCE AND PAYMENTS WILL BE MADE DIRECTLY TO THEM.

WAIVER OF LIABILITY

PLEASE BE ADVISED THAT CERTAIN SERVICES SUCH AS MANUAL THERAPY & EXTREMITY ADJUSTMENTS ARE NOT CONSIDERED BILLABLE BY YOUR INSURANCE COMPANY. I WILL ASSUME FULL REPONSIBILITY FOR THE PAYMENT OF THESE SERVICES.

I FULLY UNDERSTAND AND AGREE TO THE ABOVE INFORMATION. I AUTHORIZE CVCW TO USE AND DISCLOSE HEALTH INFORMATION REGARDING MY CARE FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATION PROCESS.

SIGNATURE OF PATIENT_____ DATE_____

SIGNATURE OF PARENT, LEGAL GUARDIAN, OR POA_____