PRECISION
CHIROPRACTIC

Financial & Cancellation Policy

Every effort is made by our office to keep the cost of care reasonable and convenient for our patients. Our office will file with your insurance company if you have chiropractic benefits, or provide you with the necessary information to file with your insurance company for direct reimbursement.

Prior to treatment we will help to identify the patient's responsibility for payments based on the information provided to us by your insurance company at the time of service. This may not include up to date information regarding your current deductible or remaining available maximum at the time of service. Please know that insurance is a method of reimbursement and is not a substitute for payment.

Account balances are due and payable in full by the responsible party 30 days after the service date, regardless of claims paid. If insurance is not applicable, payment is required at time of service.

Cancellation Policy: If canceling/rescheduling within 24 hours of scheduled appointment time, $25 is due immediately at the time of cancellation/reschedule. If canceling/rescheduling within 4 hours of scheduled appointment time, $50 is due immediately at the time of cancellation/reschedule. If no cancellation/reschedule notice is given prior to the scheduled appointment time, the full cost of the scheduled visit will be charged.

We understand that emergencies can arise and we will handle those on a case by case basis. Prepayment may be requested prior to scheduling your appointment if cancellations occur on a regular basis. If you have any questions about the cancellation policy, please let us know.

By signing below I understand that I am responsible for charges whether or not my insurance covers them. I further agree to the above policy as it applies to my account. I authorize Precision Chiropractic to release to my insurance company any information needed to aid in the processing of my claims. I have read and understand the cancellation policy and accept responsibility for cancellation charges and authorize Precision Chiropractic to charge my credit/debit card on file for those charges.

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Print Name of Patient/Responsible Party

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Signature of Patient/Responsible Party

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Signed on Date