Patient Name:_____

Financial and Cancellation Policy

Thank you for choosing Hofman Chiropractic & Wellness (Dr. Heather Hofman DC, Dr. William Hofman DC) as your Chiropractic Providers. We recommended you read, agree to, and sign the following statement of Financial Policy prior to starting treatment.

1. **It is your responsibility to verify with your insurance plan/carrier prior to each appointment that your doctor is a participating provider.** Please verify that service such as office visits, X-Rays, and in-office procedures do not require pre-authorization or referrals from the patient's primary care physician.

2. **Payment is due at the time services are rendered, including co-payments and deductibles.** Your insurance is billed as a courtesy but it is not a guarantee of payment. We accept cash, check, Visa, and MasterCard.

3. **Written or verbal authorizations from insurance plans or management groups are not a guarantee of payment.** All claims are reviewed by the insurance carriers after services are rendered and authorizations can be denied at time of review. **Denied claims become the patient's responsibility. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances of certain procedures or limit the length of the sessions. Ultimately all charges are your responsibility. The Electro-Acuscope and Myopulse Therapy is the therapeutic modality of choice by Dr. Heather Hofman DC. The Electro-Acuscope is a Class 2 Medical Device for pain management. The Electro-Acuscope is not covered/reimbursed by most major medical insurance companies, as it does not have a billable code. The Electro-Acuscope is a non-covered service and is the responsibility of the patient as an out of pocket charge of $45.00 per each treatment. Supplemental therapeutic modalities such as ultrasound, electrical stimulation, etc. may be used in place of the Electro-Acuscope therapy and are billable modalities to most insurance companies. Although, these therapies are not always reimbursable and dependent on the patients insurance coverage, may become the patients responsibility for payment.**

4. Statements are mailed after the insurance company has paid their portion. The account is then payable within 30 days for unpaid insurance charges or missed appointment fees. Overdue accounts are subject to a $15.00 rebilling fee each 30 days it goes unpaid. Accounts 90 days past will be subject to collection by an external agency unless financial arrangements are made within our office.

5. All supplies, which are not billable to your insurance carrier, must be paid for at the time they are dispensed.

6. **APPOINTMENTs THAT ARE NOT CANCELLED WITHIN 24 HOURS TO THE SCHEDULED APPOINTMENT TIME WILL BE CHARGED $45.00 MISSED APPOINTMENT FEE. PLEASE BE SURE TO ADVISE THIS OFFICE 24 HOURS IN ADVANCE OF CANCELLATION. Please arrive on time to appointments to insure you receive your full session of treatment.**

7. Whenever our office refers you to outside laboratories, hospitals, physical therapy or tests, be sure to verify that pre-authorization is not required and that your insurance participates with the facility.

8. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Private Insurance, and or other health plans.

9. I also acknowledge receipt of the notice of Privacy Practices.

I HAVE READ THE ABOVE AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS ARE SET FORTH.

Print name of the financially responsible party _____

SIGNATURE_____DATE_____