Goodwin Chiropractic Office Policy

Goodwin Chiropractic believes that a clear definition of our office policies will allow the patient, the office staff and the doctor to concentrate on the big picture—"REGAINING AND MAINTAINING YOUR HEALTH"

APPOINTMENT POLICY

It is in the best interest of our patients that you inform us if you will not be able to make your scheduled appointment so that we may give your slot to another patient. For Massages, you must cancel your massage at least 24 hours in advance. Failure to do so will result in a $20 No Call No Show Fee.

HIPPA DISCLOSURE

Goodwin Chiropractic follows the Health Insurance Portability and Privacy Act of 1986. We will not give out or share your information without your written consent. At times we may discuss out loud with you your information, if at any time you feel uncomfortable just let us know and we can discuss the matter in private. Goodwin Chiropractic is an open public treatment facility. This means others may see you receive treatment in the office and possibly through a window from outside. If this is a concern please let us know. Our employees may call you regarding your treatment, to follow up on your financial information, or just to see how you are feeling. We may call and leave our company name on your answering machine. By signing below you accept these terms.

FINANCIAL POLICY

To avoid undue hardship for our patients and to keep our costs down so that we can provide care to patients in our office at a reasonable rate, payment is due at the time of service. Failure to do so will result in a $20 fee for every missed payment. I understand that I am responsible for payment of all deductibles and copayments related to my care. I understand that Goodwin Chiropractic requires auto debit for all services in the office, this will require that I leave a Visa or MasterCard on file; all stored cards are stored on a secure and encrypted server through the company X-Charge. When I come in for an appointment, my fees due will be drafted at the time of service. I understand that if I have a balance for medical services not paid (deductibles, co insurances, etc.); I will make a minimum payment of $50.00 a month or 20% of the outstanding balance whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay a 33% collection fee, and any court and attorney fees in the collection of my account, in addition I agree that if I have any unpaid balance with this office this is over 30 days old will accrue a finance charge of 1.5% or.50 per month, whichever is greater. I understand this if a check or debit is returned for insufficient funds; I will be charged a $25.00 service charge.

As a courtesy to you we will bill any insurance that we are in network with, and will bill out of network insurance at our discretion. Verification of benefits from any health insurance, employer or auto insurance company is not a guarantee of payment to our office. If you have an insurance policy that pays you directly, you are responsible for bringing in the Explanation of Benefits and checks signed over to our office in order for us to reconcile your account. If you do not bring this information to us, you will be responsible for the entire amount billed to your insurance. You are ultimately responsible for your charges incurred in our office. Therefore, you should be involved with the timely reimbursement from your insurance to our office on your account. In addition, you should be advised that you are responsible for any services that are unpaid by your insurance company after 90 days. If your intention are for you to receive reimbursement from your insurance company for services rendered, you are still responsible for payment at the time of service. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the fee schedule regardless of the outcome of my case.

It is not our policy for your treating physician to prescribe your care and treatment plan based upon your finances. If you feel you cannot comply with the treatment plan your doctor prescribed, please make arrangements with the billing specialist who will work with you on any financial concerns.

I have read, understand, and accept the terms of Goodwin Chiropractic's Office Policy

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Patient Signature Printed Name Date