Rise Chiropractic and Wellness

Elevated Healthcare for the Whole Family

Patient Name _____ **Date of Birth** _____

Financial Policy

To maintain compliance with federal and state regulations regarding health care costs and fees, and to keep your health care costs affordable without compromising the care you need, our office will be adopting the following collections policies, effective January 1, 2025:

Patients with Insurance: If we are in-network with your plan, and have a verified/checked policy on file, we will bill your insurance. **All estimated fees not paid by your insurance plan, including examinations, co-pays, co-insurance and/or deductible amounts, non-covered services, maxed benefits, etc., must be paid at the time of your visit**. If we cannot verify your benefits prior to your visit, you will be treated as a time-of-service patient, until benefits can be checked, and coverage verified. Verification of benefits does not guarantee payment by your insurance company. After insurance benefits and payments have been applied, the remaining balance will be your responsibility.

Cancelled Appointments Within 24 Hours of Appointment: You will be charged a $30 fee for appointments cancelled within 24 hours of your appointment time.

No-Show Appointments: Appointments missed without the patient notifying the office prior to the scheduled appointment will result in a fee equal to the amount typically charged for the appointment type scheduled.

All patients must have a credit card on file. In the event that services are not paid for on the date of service or services denied by your insurance company, this card will be charged to cover your outstanding balance. If the balance is $100 or more, you will be notified prior to us charging the card on file.

For balances greater than $100.00, we have short-term in-house financing options available to those patients who need to pay their bill out over a longer period. If you would like more information about the financing options, please discuss them with the Clinic Director.

By signing below, I acknowledge that I have fully read and understood the financial policy:

_____ _____

Signature Date

List all family members you are responsible for payment:

_____ _____

_____ _____

_____ _____

***Patients whose insurance plans prohibit up front collections will have their portion automatically debited from their card on file upon receipt of insurance remittance.**