

# EnWell Chiropractic & Acupuncture

## Fee Schedule and Payment Policy

- Initial history, exam, consultation & Treatment \$150 - \$300
- Re- Examination \$50 - \$75
- Treatment \$75 - \$200
- Braces, supports, and supplements \$5 - \$150

**\*For Self-Pay (No insurance or no coverage for Chiropractic) patient, 20 % TOS discount will apply for treatment if you choose TOS discount.**

**\*A Patient has Chiropractic coverage, but no coverage for Acupuncture, who would like to get both Chiropractic and Acupuncture. We have a discount for Acupuncture treatment. Please Ask for front desk.**

I have read the above fees and understand the cost of my treatment with my doctor. I understand that I am responsible for payment of all deductibles, co-insurance, and co-payments related to my treatment, and if the insurance company declines payment, I am responsible for full payment of all of my treatment. I further understand that if my treatment is associated with personal injury or automobile accident claim, all medical bills will be paid at 100% of the fee schedule regardless of the outcome of my case.

I understand that if I have a balance for medical services not paid, I promise to pay any and all fees of my account. I understand that if a check or debit is returned for insufficient funds, I will be charged a \$25 service charge. I further understand that if I do not make payments after receiving 3<sup>rd</sup> statements, my case will be sent to the collection agency. I have Read and fully understand the above financial and prices.

\_\_\_\_\_  
Signature of Patient, Parent, or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name Patient, Parent, or Guardian

\_\_\_\_\_  
Relationship to Patient

# **EnWell Chiropractic & Acupuncture**

## **CANCELLATION & NO-SHOW POLICIES**

**Please understand that ENWELL CHIROPRACTIC & ACUPUNCTURE does not over book our schedule to cover for patients canceling at the last minute or not showing up. We reserve your appointment time for you specifically. If you cancel on short notice, do not show up, or show up very late – that is lost opportunity that another patient could have used to be treated.**

We understand unanticipated events happen occasionally in everyone's life, but in our desire to be fair to all patients and maintain a viable practice, the following policies are honored.

### **CANCELLATIONS**

24 hours advanced notice is required when canceling any appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged \$75. This amount must be paid prior to your next scheduled appointment.

### **NO-SHOWS**

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "No-Show" and will be charged \$75 for their missed appointment. This amount must be paid prior to your next scheduled appointment.

### **LATE ARRIVALS**

If you happen to arrive late for an appointment, your visit will likely be shortened and end at the originally scheduled time in order to accommodate other patients whose appointments follow yours. Depending upon how late you arrive, your doctor will have to determine if there is enough time remaining to start your treatment. Regardless of the length of the treatment provided, you will be responsible for the full amount of your scheduled appointment. Out of respect and consideration for your doctor and other patients please plan accordingly and be on time.

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Signature of Patient, Parent, or Guardian

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Date

# EnWell Chiropractic & Acupuncture

Name: \_\_\_\_\_ Date: \_\_\_\_\_ File# \_\_\_\_\_

## ENWELL CHIROPRACTIC & ACUPUNCTURE

### Privacy Practices Acknowledgment: HIPPA

As of April 2003, all health care providers are required by law to provide you the patient with a Notice of Privacy Practices. The privacy of your protected health information (PHI) is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of care and services you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. You are being provided a Notice of Privacy Practices which explains how we may use and share PHI about you. If, at any time, you have questions or concerns related to your protected health information, please feel free to speak with any one of our staff.

### Signature on file form

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all insurance companies related to my care at ENWELL CHIROPRACTIC & ACUPUNCTURE.
- I authorize release of all medical / health information from any other provider I have used previously to ENWELL CHIROPRACTIC & ACUPUNCTURE and any agent working on their behalf.
- I authorize ENWELL CHIROPRACTIC & ACUPUNCTURE and any agent working on their behalf to obtain payment from my insurance company and / or attorney.
- I authorize payment to be made directly to ENWELL CHIROPRACTIC & ACUPUNCTURE.
- I permit a copy of this authorization to be used in place of the original.
- I permit ENWELL CHIROPRACTIC & ACUPUNCTURE and any agent working on their behalf to contact me by means of the home, work and / or cell phone number(s) I have provided on the patient information form.
- I permit ENWELL CHIROPRACTIC & ACUPUNCTURE and any agent working on their behalf to contact me via written communication to my home address given on the patient information form.

I have received the Notice of Privacy Practices and have reviewed it and I have reviewed the signature on file form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name printed: \_\_\_\_\_