**FINANCIAL POLICY**

1. **General Financial Policy**
	1. **It is our policy to collect charges for services as they are rendered.**
	2. **Accepted methods of payment are as follows:**
		1. **Cash**
		2. **Checks**
		3. **Credit Card**
		4. **Flex Plan and Health Saving Account**
	3. **Billings for any unpaid charges are sent out on a monthly basis.**
	4. **Payment arrangements may be made upon approval by phone or in person. Final approval will be in the form of a written contract of payment, which will be considered binding.**
	5. **On accounts, 90 days or older, a *finance charge of 3%* will be added to the balance if no payment is received.**
2. **Medicare does not cover myofacial treatment. We do not accept assignment for this form of payment.**
3. **No Show, Rescheduling, or Cancellation of Appointments**
	1. **You must give a 24 - hour notice of cancellation or rescheduling of an appointment. (*Except for emergencies.*)**
	2. **Failure to give notice of either missed, cancellation, or no – show of an appointment will result in the charge for the full amount of your treatment.**
	3. **Please understand that we have reserved this time for you, it is not fair to others that may need this time for treatment.**
4. **Collections – This is a last resort measure**
	1. **Accounts reaching 90 days with no personal payment will be placed in collections.**
	2. **If you have arranged for payment with our office and this is not carried out or followed through as you have agreed, your account will be placed in collections or small claims court, pending the balance of the account.**
5. **Exceptions**
	1. **Worker’s compensation**
		1. **The patient must report injury to employer prior to treatment. Bring all Workers’ Compensation forms from the employer, signed. If applicable, a written referral from a Physician, Chiropractor, or Dentist.**
		2. **Patient must complete Worker’s Compensation/Injury questionnaire.**
	2. **Liability**
		1. **The patient must provide the name, address, and phone number of all attorneys and insurance companies so we may bill this directly. The claim number for this incident and a letter of protection from your attorney, if one has been retained, will be required.**

**I HAVE READ THE ABOVE AND UNDERSTAND, THIS ACCOUNT IS MY RESPONSIBILITY.**

**PATIENT/GUARDIAN**

**Signature Date**

**Print**