Cornish Family Chiropractic Center

OFFICE POLICY

We believe that a clear definition of our office policies will allow you, the patient, and us, the doctor, to concentrate on the big issue:
REGAINING & MAINTAINING YOUR HEALTH.

APPOINTMENT POLICY

Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the doctor feels is best for you. Because your condition requires numerous appointments over the next few weeks or months, we have designed a Multiple Appointment Program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine.

The frequency of your visitation schedule is of paramount importance to your results, so we ask each patient to assume responsibility of strict adherence to the appointment program as it is designed for optimum results.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of the visits that counts, not the days on which you receive the service. It is the patient's obligation to **make up a missed appointment within seven (7) days of any cancellation.**

When entering the office on any given visit, please "sign-in" at the front desk. We sincerely attempt to honor all appointments at the scheduled time. If you are late, you may be asked to wait for the next available appointment.

Big Idea Class

The purpose of recommending that all new patients attend a Big Idea Class is to enlighten you about your body, especially the spine and nerve system. Since chiropractic is not the practice of medicine, and may be new to you, it is essential to understand how to help us help you get well more quickly. We have found that patients who have attended our class seem to respond better, because they understand the cause of the problem and what we are attempting to do to correct it.

Your attendance at the Special Consultation is highly recommended!
It is part of your program of care.

We request that you bring a partner, so he/she can understand chiropractic. Friends and relatives may also attend, as this is a terrific way for them to appreciate the value of chiropractic care. The class is approx 35 minutes with Q & A following.

FINANCIAL POLICY

1) **Services not covered or applied to a deductible are PATIENT RESPONSIBILITY.**
2) **All payments are expected at the time of service, or at the end of each week. Patient balances may not exceed more than $50 at any given time.**
3) **Returned checks and balances over 30 days may be subject to additional collection fees and interest charges.**
4) **10% of an outstanding balance MUST BE PAID BEFORE YOU RECEIVE ADDITIONAL CARE IN THE OFFICE!**
5) **We do not own your insurance policy however we will as a courtesy verify benefits for your policy. PLEASE NOTE: It is your responsibility to know the limitations of your policy. The insurance company makes it clear that they DO NOT guarantee the benefits we receive over the phone. If a procedure is returned to us unpaid IT IS PATIENT RESPONSIBILTY.**

MEDICARE

1) IMPORTANT!!! MEDICARE DOES NOT PRESENTLY COVER EXAMS OR X-RAYS WHEN PERFORMED BY A CHIROPRACTOR. THESE WILL BE YOUR RESPONSIBILTY. MEDICARE PATIENT'S ARE ALSO SUBJECT TO A YEARLY DEDUCTIBLE. IF YOU HAVE A SECONDARY INSURANCE WE WILL BE HAPPY TO SUBMIT CLAIMS FOR YOU, HOWEVER PLEASE NOTE THAT THERE IS LESS THAN A 1% CHANCE THAT A SECONDARY INSURANCE POLICIEY WILL COVER THE INITIAL EXAM! YOUR SIGNATURE BELOW INDICATES YOU HAVE BEEN MADE AWARE OF THE POSSIBILITY OF THESE SERVICE BEING BILLED AS PATIENT RESPONSIBILTY.

I have read the above policy and had it explained to me by a member of the clinic staff. Should I have any questions regarding my account or personal finance concerns, I am aware that I may contact Tina at the business office at anytime to address any questions or concerns I may have. Our office phone number is: (207) 625-8100.

Initials: ___________ Date: _____________

Assignment of Insurance Benefits Clause:

I, __________________________ authorize my insurance company to pay Cornish Family Chiropractic for all services rendered. I am also aware that I am personally responsible for any charges my insurance company refuses payment on, UNLESS covered under a contract of a secondary plan or separate plan with Cornish Family Chiropractic.

Signature:___________________________________ Date:________________________________

CA: Initials:_____________