Patient Name __________

Welcome to Lowman Chiropractic & Acupuncture

We would like to take the time to welcome you to our office and thank you for choosing us to be a part of your healthcare team. It is our goal to provide you with the best possible care and deliver it in a timely manner. However, for us to be able to do that, we need to ask for your co-operation. Below is a list of our office policies and procedures. We ask that you please respect these policies so that we may serve you in a timely manner.

If you have any questions or concerns, please ask prior to treatment or during your initial consultation with Dr Lowman.

- All Co-Pays and Co-Insurance are due at the time service in rendered. (No Exception)
- We are happy to bill your insurance; however, it is your responsibility to know if you have Chiropractic/Acupuncture coverage and any limits places on that coverage. This includes number of visits, annual deductible (and the amount of that deductible). Your insurance company should provide you with a list of in network providers.
- 100% of Acupuncture payments will be collected at the time of service.
- Appointment are required for additional visits.
- 24 Hour notice is required for cancelling appointments
- A $45.00 missed appointment fee will be applied to your account without proper notification. This must be paid before your next visit/treatment.
- Our office accepts cash, check, Visa, Mastercard and Discover Cards only.
- Checks returned to our office for insufficient funds will be subject to a **$50** NSF fee and will need to be settled before any additional visits will be made.
- Personal Injury / Automobile injury Cases, you must provide your own health insurance information and or Auto insurance that has med-pay coverage in order to be accepted as new case. You will still be subject to any copays, co-insurance, limits and deductibles. Third Party insurance will not be billed from our office. Any balance not covered by your insurance will be your personal responsibility to pay this office and are due within 30 days of request of payment from this office.
- Auto injury cases in which you have legal representation, you and your attorney will be required to sign a lien agreement before treatment. This is to ensure our office is paid promptly after your case is settled / closed.
- All Patients must sign the Arbitration Agreement prior to service at Lowman Chiropractic.

I have read, understand and agree to the above office policies as they have been provided to me. I also understand that failure to accept these policies or provide my signature will result in services not being rendered by Lowman Chiropractic.

Patient Name (printed)________________________ Signature _______________________ Date___/___/____

Lowman Chiropractic & Acupuncture New Patient Intake Form

Today's Date ____/____/_____

Title: ____ **First Name** ___________________ **Middle Initial** ____ **Last Name**__________________

Date of Birth ______/______/_______ **Sex:** ☐ Male ☐ Female

Social Security Number: ______-_____-______ **Marital Status:** ☐ Single ☐ Married ☐ Widowed

Address Line 1 ____

Address Line 2 ____

City _______________________________ **State** ___________________ **Zip Code** ______________

Home Phone (_____) ________-___________ **Work Phone** (_____) _________-_____________

Cell Phone (_____) ________-___________ **Cell Provider (For Text Reminders)** ____________

Email __________________________________ **Preferred Contact Method** Email ☐ Text ☐

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Spouse / Emergency Contact Information

First Name ___________________ **Middle Initial** _____ **Last Name** _________________________

Home Phone (_____) _______-__________ **Work Phone** (_____) _________-____________

Employer Information

Name ____

Occupation _________________________ **Job Description** _____________________

Address ____

City ________________________________ **State** _________________ **Zip Code** ______________

Emergency Contact

Contact Name ____________________________ **Relationship to Patient** ___________________

Contact Home Phone (_____) _______-________ **Cell Phone** (_____) ________-______________

How did you hear about our office? ____

Patient Name __________

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other ______________			

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar Spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic Spine	☐ Knee
☐ Carpal Tunnel	☐ Gastrointestinal	☐ Urogenital	☐ Hernia
☐ Other ______________			

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other _________

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling
Other _________________		

Occupational Activities: (Check one that best describes your job description)

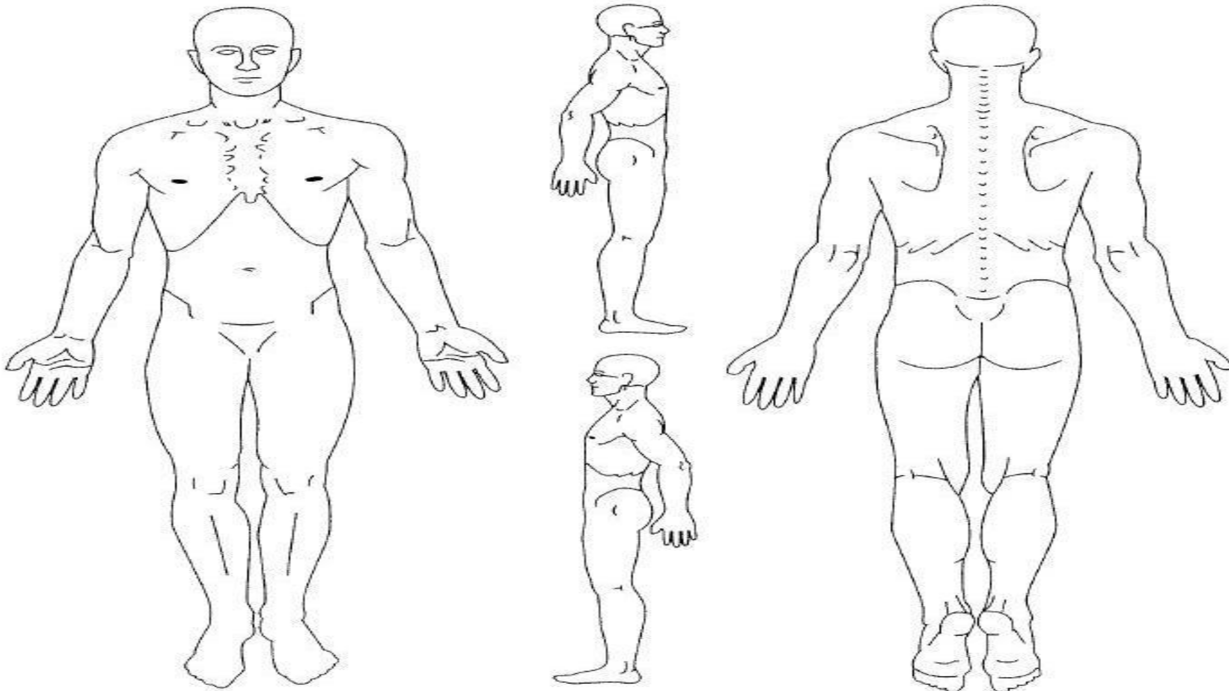
☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper
☐ Other ________________			

Are you pregnant? Yes_____ No ______N/A______

Patient Name __________

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Stabbing** **T=Tingling** **A=Dull Ache**



Describe your symptoms in order of severity, with worse symptom being #1: ___________________
____
____
____

When did your symptoms begin? **Month**_____________ **Day**___________**Year** ______________

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work Related Accident ☐ Other_____

How or when did your symptoms begin?
____
____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day)	☐ Frequently (51-75% of the day)	☐ Occasionally (26-50% of the day)	☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp	☐ Dull ache	☐ Numb	☐ Shooting
☐ Burning	☐ Tingling	☐ Stabbing	☐ Other ______

Doctor's Signature ____

Patient Name __________

Payment/Insurance Information

WE DO NOT PARTICIPATE WITH UNITED HEALTHCARE

If you are being treated as the result of an Automobile Accident and have legal representation a lien agreement must be signed prior to treatment. (Patient Initial) ______________

Who is responsible for your bill? ☐ Self ☐ Health Insurance ☐ Spouse ☐ Worker's Comp
☐ Auto Insurance ☐ Medicare ☐ Medicaid Other_________________________________

Personal Health Insurance Carrier: _______________________ Insur. Card ID # ___________________

Policy Holder's Name: ________________________________ Group # _________________________

Policy Holder's Date of Birth ______ / _____ / ______ Primary Care Physician _________________

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐Yes ☐No Date: ____/____/____ Time: ______am / pm

HIPAA Privacy Practices

- I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name ____

Patient's Signature ____
Date__________________

Is there anyone that you would like to give us permission to talk to about your medical and or financial case in our office?

Yes_____ No _____ Name:________________________________ Relationship__________ Phone#____________

Consent to Treat a Minor:
I hereby authorize Lowman Chiropractic and Acupuncture to administer care as deemed necessary to my minor son/daughter _______________________________(Minor's Printed Name)

I further acknowledge that I am responsible for making medical decisions for the above-named individual and therefore I am also acknowledging full responsibility for treatments he/she receives at Lowman Chiropractic and Acupuncture.

Guardian / Spouse's Signature Authorizing Care _______________________________

Date__________________

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OT

Please Sign and Date Line 12
Sign Line 13
This form allows us to bill your insurance carrier electronically.

ATES RELATED TO CURRENT SERVICES YY MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Desig

$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR

A. B. C. D.
E. F. G. H.
I. J. K. L.

ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd.for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Patient Name __________

Medicare Patients Only, Please Read and Sign

A. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for Items/services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Items/services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Examinations (E/M) X-ray Physical Therapy Acupuncture Durable Medical Equipment Vitamins and Analgesic Creams	These are NON-COVERED items and or service that Medicare will not covered when ordered by at Chiropractic Physician.	$80.00 $30-$150.00 $40-$120.00 $45.00 $60.-$150.00 $15 - $45.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Items/services** listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **Items/services** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **Items/services** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **Items/services** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

Patient Name __________

To help us ensure clarity of communication please initial the following:

_____ To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be detrimental to my health. It is my responsibility to inform Lowman Chiropractic & Acupuncture of any changes in my health status.

_____ I understand that **I am liable** for all charges for services rendered and I agree to make payment on my account within 30 days of notification of any balance due. Failure to make these payments will result in further collections including but not limited to 18% interest, collection fees, court costs and attorney fees.

_____ I authorize Dr. Lowman and the staff of Lowman Chiropractic & Acupuncture to release any and all medical or financial information needed in order to process claims or seek further treatment for my condition.

_____ I authorize Dr. Lowman and the staff of Lowman Chiropractic & Acupuncture to request medical records from any other treating physician or facility as it may pertain to my current medical condition.

_____ I have been advised of my rights and responsibilities and agree to receive treatment in this office and adhere to all office policy and procedures.

_____ *Our office has a zero-tolerance policy regarding harassment of our office staff; any abusive calls, threatening language or referencing such will result in the immediate termination of treatment from Lowman Chiropractic and Acupuncture.*

Name of Patient / Guarantor ______________________________ Date: _____/_____/__________

Patient / Guardian Signature ______________________________

Patient Name __________

Insurance Policy Information

We understand how confusing insurance coverage can be. The information below is intended to inform you of some insurance coverage terms. Some or all the terms may be part of your insurance policy. It is your responsibility to know your insurance coverage, limitations and amounts before making any appointment for your first visit and services.

WE DO NOT GUARANTEE ANY BENEFIT COVERAGE FROM YOUR INSURANCE.

Unfortunately, insurance companies often mis-quote benefits to health care providers. While we know how frustrating it can be, Lowman Chiropractic is not liable for any misinformation given. **We accept assignment as a courtesy to our patients and will gladly submit the insurance paperwork on your behalf; however, you the patient, remain responsible for the cost of serviced rendered.**

Insurance carriers may require our patients to be responsible for the following:

- Your deductible, which is the amount that must be paid by you before your insurance company will pay your health care provider.
- Your co-payment is the amount that your insurance policy requires you to pay for covered services at the time services are rendered. This amount is either a percentage or a flat fee that your insurance company holds you responsible for.
- **Co-insurance:** may be due from the patient in addition to your co-payment and deductible.
- **Out of network**: This is when our office does not have a written agreement with a particular insurance carrier and insurance reimbursement rates are lower to the provider, resulting in a higher percentage (or all) of the bill being passed on to the Patient.
- **Monthly Premiums**: this is the amount that you pay each month to your insurance carrier / provider, usually taken out of your paycheck, for your insurance coverage. This is separate from your payment responsibility to any doctor, or hospital. It does not apply to service(s) rendered to you from our office.

The information provided herein does not constitute legal advice. Patients are advised to consult an attorney about any information regarding their rights and legal entitlements. Lowman Chiropractic and Acupuncture takes no responsibility for any such information reflecting herein.

Lowman Chiropractic and Acupuncture will gladly submit claims to your insurance carrier on your behalf, However, any claims not covered by insurance carrier for any responsibility will remain the patient's responsibility. Should there be any balance on the account the patient agrees to make payment in full or per agreed amount within 30 days of being notified of any balance due.

Please sign your name below to indicate that you have read the above information and understand it. If you do not understand please ask us. Failure to agree and sign this document will result in services being denied at this time

______________________________	______________________________
Patient Name (print)	Patient Signature
______________________________	______________________________
Date Signed	Witness

Patient Name __________

Authorization To Release Information: Lowman Chiropractic is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Lowman Chiropractic and Acupuncture, including its designated associates and assistants. I hereby release Lowman Chiropractic and Acupuncture from any consequences and/or liability concerning the same.

Assignment of payment: My attorney and/or insurance company are hereby requested to pay directly to Lowman Chiropractic and Acupuncture any monies due on my account, the same to be deducted from and settlement made on my behalf. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that it is not covered by my insurance policy or if for any reason the insurance company and/or attorney refuses and/or fails to pay my claim.

Unpaid Insurance Balances: I understand and agree that should there be any unpaid insurance balance for sixty (60) days, such balance automatically becomes my responsibility to pay.

Medicare Assignment: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Safety Notice: I understand that chiropractic adjusting tables and office equipment are not intended to be played with/on or around by children. I agree to supervise my children while at Lowman Chiropractic and Acupuncture to prevent any injury from touching the adjusting table mechanics or any other office equipment. I understand that Lowman Chiropractic and Acupuncture or any employee, intern, associate or owner may not be help responsible for any injuries resulting from a lack of proper supervision of children.

Obligations as to services: I hereby acknowledge that I am receiving (or about to receive) health care services at Lowman Chiropractic and Acupuncture, that I have been advised that Lowman Chiropractic and Acupuncture is willing to wait for payment for the services rendered so long as there continues to be a likelihood that payment will be made either by my insurance company and/or out of the settlement of my liability case.

I understand and agree that, in the event

A. It is determined that there in no insurance company coverage (obligation) to pay for Lowman Chiropractic and Acupuncture services.
B. The insurance company for the undersigned refuses to acknowledge and accept assignment to Lowman Chiropractic and Acupuncture to take other actions for the protection of the interest of Lowman Chiropractic and Acupuncture.
C. My attorney fails and/or refuses to agree to protect the interest of Lowman Chiropractic and Acupuncture as determined in its sole discretion, or
D. I fail to retain an attorney

Then the payment of services at Lowman Chiropractic and Acupuncture will be made on a current basis and my bill paid in full within thirty (30) days from my last treatment.

Interest and collection: I acknowledge and agree that should my account become more that thirty (30) days overdue. I will incur interest on my past due balance of (18%) per annum. I further acknowledge and agree that Lowman Chiropractic and Acupuncture shall be entitled to reimbursement from me for ANY legal cost, including attorney fees, court costs and a twenty-five-dollar ($25.00) collection fee for all efforts to collect on any past due account with Lowman Chiropractic and Acupuncture.

By my signature below, I make the foregoing authorizations, assignments and agreements.

______________________________	______________________________
Patient Name (print)	Patient Signature
______________________________	______________________________
Date Signed	Witness

Patient Name __________

What To Expect After Your First Treatment.

Please read the following and sign to indicate that you understand the information and instructions that you are being given. If at any time you have a concern, please feel free to ask.

1. If this is your first adjustment or is it has been some time since your last adjustment, we would like for you to know that you may feel some soreness or discomfort in or around the adjusted area for a few hours and possibly a few days. Do not worry, this is a normal reaction.

2. If you are feeling any discomfort or soreness you may use ice packs on the affected area. Ice therapy will help with the inflammation that can occur after an adjustment of the joints. When using ice packs please do the following: Use for 20-minute intervals on the affected area followed by a 40-minute break (this can be done as needed). Do not apply ice directly to bare skin. Always use a thin covering such as a towel or t-shirt and be sure to wrap the ice pack to help retain the cold.

3. DO NOT USE HEAT UNLESS SPECIFICALLY INSTRUCTED BY DR LOWMAN. Heat may aggravate your injury.

4. DO NOT do any heavy lifting or repetitive movements until the doctor has cleared you to resume normal activities. Activities such as running, tennis, golfing, skiing, weightlifting, raking and digging, pulling weeds, housework should be avoided as much as possible until advised to do so by Dr Lowman. Continuing such activities could re-injure or aggravate your condition. The Doctor will advise you as to which activities you may or may not do depending on your current condition and level of pain.

5. You may return to work or school after your appointment unless indicated otherwise by Dr. Lowman

6. If you experience any sudden sharp or severe pain or if you have swelling or any unusual pain after treatment, please contact our office at 540-886-5500

Patient Signature ____________________ Date____/____/_____

Patient Name __________

Patient Information and FAQ

Keep Your Appointments.

Dr Lowman will establish a schedule of care that is specific for you and your needs. It is imperative that you follow his guidelines in order to help correct the cause of your problem in the most efficient manner possible in order for you to achieve the results we both desire. Missing or delaying appointments can cause you to relapse or cause new conditions to surface that could require additional visits or other forms of care to be necessary which can be very costly to you. It is our goal to get you back to peak performance as quickly as possible.

If you need to change the time of your appointment, it is best to call and reschedule for a different time on the same day. If you need to change the day, we ask that you make that appointment as soon as possible, preferably the next day. Regardless, it is extremely important that you keep to your schedule so that you do not lose ground on your recovery.

As a courtesy, we will contact you if you are late for an appointment and will contact you to reschedule any missed appointments in order to keep you on track for a quick recovery. There is a $45.00 missed appointment fee that will be applied to your account if you miss an appointment and do not contact our office.

Allow 7 Business days for Records or Paperwork Requests.

Any requests for copies of records, or specialized receipts (AFLAC, flex spending plans, or mileage requests) require a 10-day advance notice and copy fees will apply.

Keep your account current

In order to keep cost down, payment is expected at the time services are rendered. We reserve the right to deny services at this office for lack of payment. Interest charges of 18% are applied to all balances over thirty (30) days old. Accounts over ninety (90) days will be placed in collections which are subject to additional collection fees including court costs and attorney fees. A $50-dollar service charge will apply to any returned check and further check payment will not be accepted.

Communicate Any Changes

It is your responsibility to notify our office as soon as possible of any injuries, accidents, or illnesses that may have occurred since your last visit so that we may provide you with the appropriate care and allow for proper determination of carrier responsibility. You must also notify us of any insurance changes (change in coverage or termination of coverage), along with any changes in personal information such as name change, address change, employment change or contact phone number changes. Our office bills insurance as a courtesy to you; however, payment is ultimately your responsibility and can be collected from you at any time.

We Welcome Feedback

If you have any suggestions or comments, please feel free to let us know. We value your opinion and input.

Tell Others About Your Positive Experience

Share your positive results with others to help them better understand the benefits of chiropractic treatment and care. When done properly it can be a safe drug-free approach to better health and quality of life.