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 and maintaining your health.

APPOINTMENT POLICY

Multiple appointments will be scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts; and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to make up a missed appointment within 7 days of any cancellation.

This office reserves the right to charge for missed appointments and those cancelled without 24 hours' notice.

When entering the office on any given visit, please go directly to the front desk and "sign-in". We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to speak to the receptionist directly.

FINANCIAL POLICY

1. It is our office policy that all services rendered in this office are billed to your insurance company, if applicable. If for any reason your insurance company rejects your claims, you are personally responsible for all charges incurred.
2. All payments, including co-pays and deductibles, are expected at the time of service or at the end of each week. Patient's balances may not exceed $150 at any time.
3. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month.
4. **A charge of $30 will be incurred for all appointments that are missed or those not cancelled with 24 hours' notice. Patients running 10 minutes late will need to reschedule.**

Appointment Reminder

Email Address_____ Patient Name _____

Cell Phone Number _____ Patient Signature_____

Cell Phone Carrier_____ Date_____