Millis Family Chiropractic (MFC) Financial Policies

Payment in full is expected on all **FIRST VISIT** services (whether you have insurance coverage or not).

All other fees are to be paid at time of service until other arrangements have been made and agreed.

Please indicate your method of payment ___ Cash ___ Check ___ Credit or Debit Card

Insurance

Insurance coverage varies greatly. We cannot predict whether your policy will cover services we provide in our office. We will verify and file insurance claims, however we encourage you to contact your insurance company to determine the amount and extent of coverage. Please obtain an **Insurance Verification Form (IVF)** from our staff to assist you in this process. If it is determined that your insurance will reimburse you for chiropractic care in our office, we will bill the insurance company and you will be responsible for any unmet deductible and co-payments.

If you have had an **Auto Accident, a Worker's Compensation Injury or a Persona Injury**, you are entitled to chiropractic benefits. If yes, please complete **Personal Injury Form (PIF)**.

Please Read and Sign

1. I have been informed that a copy of Millis Family Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" form is available for my review both in the office and on the website at www.millisfamilychiropractic.com
2. I understand that care might be given in an open setting. Private rooms are available upon request.
3. I consent to receive communication form MFC via email. Postal mail, text and telephone messaging in connection with my care ___ Yes ___ No If I should withdraw my consent, I will notify the office in writing.
4. **24 hour advance notice is required** when canceling an 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 the the full amount of your appointment.**
5. I have read, understand and agree to complete all forms necessary to allow Millis Family Chiropractic to assist me with insurance reimbursement**. I understand that I am personally responsible for all services received should my insurance fail to remit payment**.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give doctors at MFC permission to render care to me. This initial visit includes a health history, consultation, chiropractic exam and evaluation and adjustment (if appropriate).

Patient Name: (Printed) _____ Date: _____

Signature: _____

Signature of Parent (for minor): _____ Date: _____

Welcome and thank you for choosing Millis Family Chiropractic!

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