AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Irwin Family Chiropractic Clinic as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your copay/co-insurance/deductible is due when services are rendered. We accept cash, check, and debit/credit cards.
- It is your responsibility to know your own insurance benefits, including whether your insurance company covers chiropractic care, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you may be financially responsible.
- If we accept your insurance, we will bill your insurance company, less any copayment or deductible.
- If we do not participate with your insurance company, you will be expected to pay the current rate for "Cash Patients" at the end of your visit.
- I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I will be required to pay the current "Cash Patient" rate.

Patient Signature:___________________________________ Date:______________

PATIENT NO-SHOW POLICY AND PROCEDURE

It is the policy of Irwin Family Chiropractic Clinic to monitor and manage appointment no-shows. Our goal is to provide excellent care to each patient in a timely manner. In order to help patients remember their scheduled appointments, Irwin Family Chiropractic Clinic sends text message and email reminders in advance of your appointment time. If it is necessary to cancel an appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please let us know as soon as possible of the need to cancel your appointment, with at least a 24 hour notice being optimal.

If you do not cancel or reschedule your appointment, we reserve the right to assess a $45.00 "no-show" service charge to your account. This no-show charge is not reimbursable by your insurance company. You will be billed directly for it.

I understand the no-show policy of Irwin Family Chiropractic Clinic and understand that I may be charged $45.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment in advance of the scheduled appointment in order to avoid a potential no-show charge.

Patient Signature:___________________________________ Date:______________