Discover Wellness at
HealthGoals
A Center for Life Enhancement.

We at Health Goals Chiropractic believes that part of a good health care practice is to communicate our office and financial policy to our patients. We provide the best possible care for you, and we want you to have a full understanding of our policies.

1. PAYMENT is expected at the time of your visit. We accept cash, check, Visa, and Mastercard. Payment will include any unmet deductible, co-insurance, co-payment amount, charges not covered by your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit. All non-filed services are expected to be paid at the time of service.

2. INSURANCE: We are participating providers with many insurance plans. We will file all the claims for these plans. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral for your visit in our office to be covered under your medical insurance.** If our providers are out of network in your plan, you may be responsible for partial or full payment.

3. POLICY ON NON-COVERED SERVICES: This office offers access to many innovative services and procedures some of them are deemed as "not covered" by insurance. You will be responsible for payment in full at the time of service for these procedures.

4. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Health Goals Chiropractic for charges not covered by the assignment of insurance benefits and all non-covered charges.

5. AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Health Goals Chiropractic to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Health Goals Chiropractic all payments otherwise payable to me for professional services.

6. CONSENT AND DISCLOSURES: I voluntarily consent to medical treatment for myself and/or my dependents.

7. RELEASE OF INFORMATION: I hereby authorize and direct Health Goals Chiropractic to release (verbally or in writing) confidential medical information to any person, entity, government agencies, insurance carriers, or others who are financially liable to Health Goals Chiropractic for charges for medical treatment, and for quality management, utilization review, transfer of medical care, and follow up purposes. I understand that a copy of this document may be used with the same effectiveness as an original.

8. NO SHOW POLICY: We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide at least 24-hour notice. Patients who do not show up nor provide more than a 24-hour notice are considered a NO SHOW. **Patients who No-Show two (2) or more times will be asked to keep a credit card on file and will be charged $25 for all future No-Shows.**

I have read and understand the practice's office and financial policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

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Signature of Patient/Guarantor Date

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Name Printed