ADVANCED CHIROPRACTIC GROUP

5266 Hollister Ave, Ste. 101
Santa Barbara, CA 93111
Telephone: (805) 681-7322

INSURANCE FINANCIAL POLICY

It is important to remember that while most insurance policies do cover chiropractic care, you are responsible for all charges incurred at this office based on your insurance policy provisions. Your insurance company is only obligated to reimburse you according to the provisions of your contract with them.

Policies differ greatly in terms of deductibles and percentage of coverage for chiropractic care. Because insurance companies often take up to 30-60 days to pay, experience has shown that it is best for all parties when the patient pays for treatment as it is rendered, and then is reimbursed directly by their insurance company. We strongly encourage you to do this if you are able. If this method of payment is not possible for you, we can arrange to accept assignment on your claim and collect from you any deductible and co-payments as rendered.

Charges:

Exams:	Initial ($60.00 - $195.00), Progress ($35.00 - $175.00)
Normal Office Visit:	$50.00, $60.00 & $70.00 (depending on number of areas adjusted)
Physical Therapy:	$8.00 to $25.00 per modality or procedure.
Additional Expenses:	X-rays, braces, pillows, vitamins and supplements must be paid for at the time of purchase.

☐ **I understand that there is a 24 hour cancellation policy and I will be charged a missed appointment fee of $40.**

Payment Agreement:

☐ I agree to pay my deductible and co-payments at the time of service and to assign my insurance benefits to the office. *We make every effort to accurately estimate your insurance benefits. Our original quote is subject to change by your insurance company when the claim is processed. If you have further questions about your coverage and benefits, we encourage you to contact your health insurance company directly.*

Please feel free to inform the doctor of any special consideration you may need. If I suspend or terminate care at any time, any remaining balance will be immediately due and payable.

I have read, understand, and agree to the above.

Patient's Signature	**Date**