Payment Policy

Our office policy states that payment is due when services are rendered. As a courtesy to you we will file your insurance claims for you. PLEASE read carefully and check the appropriate box which applies to you.

1. _____ Uninsured
2. _____ Group Insurance: All deductible amounts must be paid by you in advance of the first billing (unless otherwise stated). Also, you must stay current with your percentage of responsibility. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects this claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own.
3. _____ Automobile Insurance: Personal Injury from an automobile accident.
4. _____ Worker's Compensation. You must have written authorization from your employer.
5. _____ Medicare
6. _____ Medicaid
7. _____ Trade Network, Inc Member.

I_____, have read the above provisions and checked one method of payment. I hereby agree that the balance is my responsibility and will pay off any balance that has gone unpaid. I understand that if collection action should become necessary for any monies due under this contract, I agree to pay any and all collection costs of up to 40%, court costs, and reasonable attorney fees.

Patient Signature: _____ Date: _____

Cancellation Policy

If you are unable to make an appointment for any reason, please call the office. As much notice as possible is always appreciated by those on our cancellation list.

- Chiropractic Appointments: please give at least a ***4-6 hour notice***
- Massage Appointments: please give a ***24 hour notice***. Therapists are on call and are only in the office when appointments are scheduled. Due to the length of the appointments, these are difficult to fill at the last minute. A **$35 fee** will be charged **to the patient** for any missed massage appointments without proper notice.

I have read the above policy and understand that I need to give advanced notice, to the best of my ability, whenever I am unable to keep my scheduled appointment.

Patient Name: _____ Date: _____

Patient Signature: _____

Life Family Chiropractic Centres
5795 Balsam Dr., Hudsonville, MI 49426