Health 1st Chiropractic & Wellness Center- 2922 Upper 55th St. East
Inver Grove Heights, MN 55076
www.healthfirstchiropractors.com PH: 651.455.5463 Email: frontdesk@healthfirstchiropractors.com

CREDIT POLICY & TERMS OF CARE

I,_____ hereby understand that all charges incurred in our office are my responsibility. I will receive a statement from Health 1st, at which time all charges are due within 30 days of the statement date. Any balance that is 60 days or older will be subject to a 40% collection fee. For your convenience, we accept cash, check, all major credit cards, and Care Credit. If a check is returned, a $25.00 fee will be added to your account.
INITIAL_____

INSURANCE: We are in network with many PPO organizations, which payment of services will be sent to Health 1st Chiropractic & Wellness Center. We are out of network with Preferred One and Blue Cross Blue Shield. Any payments or explanation of benefits will be sent to the patient. It is the responsibility of the patient to bring those in for any deductions or payments to be applied to the outstanding balance. If you do not bring in the explanation of benefits or the check from your insurance provider you will be responsible for the full amount charged. If your insurance requires a deductible, co-payment or coinsurance; it is due at the time of service. Be prepared to pay at every visit unless prior payment plan has been established in writing. INITIALS_____

I hereby authorize my insurance to pay by check and for it to be mailed directly to: Health 1st Chiropractic & Wellness Center, the expense benefits allowable as payment towards the total charges for the professional services rendered. I agree that this office be given power of attorney to endorse/sign my name on all drafts for payment of my bill.
INITIALS_____

If you are taking advantage of our $109.00 initial visit special, that payment is due on the date of the initial chiropractic exam. If the $109.00 was not paid on the initial date of service, then any charges billed will be your responsibility pending on your insurance explanation of benefits or the written payment agreement. INITIALS_____

PAYMENT PLAN: If you have an established payment plan in writing, you are responsible to report any changes that have been made to the form of payment on file. You have 5 business days to report the changes. If not, the collection process will begin on the full outstanding account balance. INITIALS_____

CONSENT FOR TREATMENT: We do not offer to diagnose or treat any disease or condition outside of the chiropractic scope of practice. However, if during your chiropractic evaluation, we encounter non-chiropractic or unusual findings, we will advise you to seek the service of a health care provider who specializes in that area. I hereby authorize the doctors of Health 1st Chiropractic & Wellness Center to administer chiropractic care as they deem necessary.
INITIALS_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I authorize the release of any medical information to process my insurance claim(s) and certify that all information given to this clinic is correct and complete. I understand that this office will not release any medical information for any reason without my consent either verbal or written.
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CLINIC INFORMATION

We are a family practice that takes pride in taking care of you and your family. For that reason every member of your family should receive their own spinal check-up, especially children. We help educate you and your family about healthier alternative healthcare choices.

CLINIC HOURS:

Mondays, Wednesdays, Thursdays	8:30 am – 12:00 pm	and	2:00 pm – 6:00 pm
Saturdays	8:30 am – 10:30 am		

MISSED APPOINTMENTS:

All missed appointments should be made up later the same day or within 24 hours. A personal care plan has been designed specifically for you and because each visit builds upon the last, it is imperative to stay on your schedule in order to achieve maximum benefits of chiropractic care. INITIALS_____

FINANCIAL AGREEMENT:

If you have the desire to receive care in our office we will make every attempt to make an affordable payment arrangement. In the unlikely event it is necessary to discontinue your care or if we regretfully find it necessary to discharge you as a patient, any outstanding fee will be due immediately. The balance in full is required at that time or we may set up a payment plan. Within 5 business days of the termination date, if neither financial options listed previously are in place, you will be sent directly to our collection agency incurring a 40% collection fee on your account.
INITIALS_____

PLEASE REMEMBER…

Spinal correction and healing takes time. To get the best results it is necessary for you to complete your recommended schedule of care and home exercises. Each treatment builds upon the last appointment and if you miss one of your scheduled appointments it will affect your results. If at any point you are not happy with your care or quality of service, please bring it to the attention of the office manager or doctor immediately, so then it can be addressed. Thank you for making the choice to put your Health 1st. INITIALS_____

I,_____ have read and fully understand the credit policy and terms of care.

(PRINT PATIENT NAME)

PATIENT / GUARDIAN
SIGNATURE:_____DATE:_____