ABA FAMILY CHIROPRACTIC
HOLISTIC HEALTH CENTER, LLC
2439 N Reynolds Rd
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Phone: 419-535-7818
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Michael A. Pickens, D.C., Director

OFFICE POLICY:

The following paragraphs provide information and outline our policies at ABA Family Chiropractic Holistic Health Center, LLC. In order to have a good working relationship for restoring and maintaining your health, we feel that it is necessary for you to understand how our office operates. Please read all the items below and state that you agree to abide by our policies by signing at the bottom of the page on the reverse side. If you have a question concerning any item, let us know, so that we may clarify it before you sign.

OFFICE HOURS:

Clinic hours are Monday 8:45 am until 7pm, Tuesday 9:30 am until 5 pm, Wednesday 9:00 am until 5pm, Thursday 10:15 am until 7:00 pm, Friday 8:45 am until 5:00 p.m., and alternating Saturday mornings from 9:30 am until 12:00 pm.

APPOINTMENTS:

Our providers schedule patients by appointment only and make a sincere attempt to adhere to their schedules. However, there may periodically be a delay in seeing you as a result of emergencies or unforeseen circumstances with treatment of another patient. When this happens, your patience is appreciated. If the provider is significantly behind schedule, the receptionist will advise you so that you may determine whether you wish to wait or reschedule.

Please be on time for your appointments. If you are late, it inconveniences the patients who are scheduled after you.

CANCELLATIONS AND MISSED APPOINTMENTS:

If you cannot keep an appointment for a **CHIROPRACTIC ADJUSTMENT**, at least **ONE (1) BUSINESS DAY** prior notice should be given to our office to cancel or move your appointment. This courtesy on your part makes it possible to give your appointment to another patient who desires to see the doctor. If adequate notice is not given, a $45.00 missed appointment fee will be added to your account.

If the appointment is for an **EXTENDED BLOCK OF TIME**, such as for X-rays, nutritional evaluation, or an extended allergy elimination appointment, an advanced notice of **THREE (3) BUSINESS DAYS** is required, or there will be a $45.00 fee per 15 min increment added to your account. For **MASSAGE APPOINTMENTS**, at least **TWO (2) BUSINESS DAYS NOTICE** is required, otherwise, 50% of the therapy charge will be added to your account.
(Note: If an appointment is missed and we are able to reschedule you for later that day, you will still be required to pay the missed appointment fee).

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INSURANCE/CREDIT POLICY:

As of January 1, 2015, our office is only billing insurance for Medicare patients. Billing other insurance companies has become extremely complex and expensive, and would jeopardize our ability to provide cost effective quality care. Therefore, we are no longer able to offer this service. We are, however, happy to give you the necessary papers and instructions for billing your insurance company.

If your insurance coverage is poor, and/or it is going to be a hardship for you to pay for your services each visit, we offer a discount plan to ease the burden. If you are interested in joining ChiroHealth USA to receive up to 20% off on chiropractic services, please ask at the front desk for information.
Payment is expected at the time of service. If you are unable to pay a balance with cash or check, our office also accepts Visa, MasterCard, AMEX, and Discover.

If your account has an ongoing unpaid balance, you will receive monthly statements and a $5.00 billing fee will be assessed with each statement. If no payment is received after a period of 3 months, your account will be sent to collections. An additional fee of 50% of monies owed will then be added to the outstanding balance to cover the collection agency's service charge.

Note
We consider the parent who accompanies a minor during the initial visit, and/or the parent having custody, to be financially responsible for the child's account and care regardless of divorce settlement.

RELEASE OF MEDICAL INFORMATION AUTHORIZATION:

I authorize ABA Family Chiropractic Holistic Health Center, LLC to release any necessary pertinent information about my medical condition to insurance carriers in order to obtain benefit/eligibility information, process claims, and request insurance appeals. I also authorize ABA Family Chiropractic to use a photocopy of my signature below as authorization until it is revoked by me in writing.

CHARGES FOR REPORTS:

If your insurance company requires a report to determine chiropractic benefits, there will be a charge for this report. However, since most insurance companies will not pay for the report that they request, you will be notified in advance of what the charge will be.

I UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE OUTLINED OFFICE POLICIES.

_____ _____

Patient or Guardian Signature/Relationship Date

_____ _____

Patient or Guardian – Print Name Witness' Signature