SCHEDULING & FINANCIAL POLICY

Dear Patients,

We are always striving for excellence in all aspects of our practice. We are committed to providing outstanding patient care as well as unmatched customer service. We are clarifying our office procedures for you, to help make your experience a better one. Please read the following and sign. If you have any questions about these procedures, please speak with your treating Doctor.

SCHEDULING:

1) All ***scheduled*** patients will receive priority. Walk-in patients may still be accepted, but only after all scheduled patients have been seen. This will be true regardless of arrival order.
2) As a courtesy to our patients, our office will provide an automated courtesy call or email 24 hours prior to your scheduled appointment. In an effort to stay consistent with your treatment plan, our office will call you to reschedule any missed appointments or unscheduled future appointments. If you are unable to keep your scheduled appointment for any reason, please contact our office at your earliest convenience to reschedule by calling (703)222-3737.
3) Missed appointments are subject to a $25 missed appointment fee in the event our office is not notified and/or the appointment is not rescheduled for a future date. We understand that extenuating circumstances may occur. In these instances, we will be happy to waive the fee on a case by case basis.

INSURANCE BILLING:

1) Your insurance policy is a contract between you and your insurance company. As a courtesy to you, we will call your insurance to verify benefits and coverage. **Please be aware that benefit verifications are not a guarantee of payment.** Additionally, as a service to you, we will bill your insurance for all visits. It is your responsibility to provide our office with your insurance details, current address, and birthdate. Please present your insurance and driver's license to us on your first visit so we can bill your insurance completely and accurately.
2) All copayments, coinsurances and deductibles will be collected at the time service is rendered. A processing fee of $35 will be accessed for any returned checks.
3) Please note that you may be subject to interest if a balance is left unpaid for 90 days. In the event, your account is sent to our collections agency, it is your responsibility to pay any and all related costs including but not limited to collection agency fees, attorney fees and/or court fees assessed in the collection of my outstanding balance of 35% until fully paid. These fees also apply to Self-Pay patients paying out-of-pocket for services rendered if their balance exceeds 90 days.

PERSONAL INJURY BILLING:

1) **MEDPAY:** "Medical Payments" or "PIP" is part of your own auto insurance policy which will immediately cover the costs of your medical expenses given by a licensed health care provider and those of any passengers in your car, up to a certain limit, regardless of fault. If payment is made by this method and you are not at-fault your insurance premiums will not be increased, and you will not have to repay any benefits (Virginia Code § 38.2-1905). This will allow you to receive the treatment you need for your injuries and pay your medical bills without the delay of dealing with the other driver's third party insurance company.
2) **PERSONAL HEALTH INSURANCE:** In the event that your health care provider is participating with your personal health insurance carrier, your medical expenses resulting

from injuries sustained in an automobile accident will be submitted daily for reimbursement of services rendered. You will be responsible for any copayments/coinsurances or deductibles that your policy requires at the time services are rendered (Virginia Code § 8.01-27.5).

3) **LIABILITY INSURANCE:** Virginia is currently an "at fault" state regarding payment of claims resulting from an automobile accident or personal injury. This means the responsible party, or his or her insurance, should cover the cost of medically necessary treatment given by a licensed health care provider. Your personal health insurance, if applicable, is also billed consistently throughout treatment. When all treatment is complete and a final statement is provided by the Doctor, billing will proceed through the at-fault party carrier or through your attorney if one was attained.
4) A lien will be provided to you to review and sign. Per Virginia Code § 8.01-26, this lien will be sent to your auto insurance, attorney and at-fault liability carrier from our office to ensure all payments are made directly to our practice for services rendered to you throughout your treatment.

COSTS OF GOODS AND SERVICES:

1) Cash patients are financially responsible for the cost of all care including; adjustments, physical therapy, x-rays and exams, supplements, herbal products, supplies and equipment. These services and/or products are to be paid at the time of service. Special orders must be paid at the time the order is placed.

MASSAGE, ACUPUNCTURE, GRASTON & YOGA:

1) All Massages, Grastons, Acupuncture and Yoga appointments are to be paid in full upon booking. **These are concierge services only and are not billable to your personal health insurance**. Notice of cancellation of a scheduled appointment must be given 24 hours prior to the session. We will apply your appointment deposit towards another session as long as it is redeemed within 30 calendar days of the original session. If the cancellation is made less than 24 hours to your appointment, you will be financially responsible for 50% of the scheduled session fee.

All financial and claim documents must be completed prior to the second visit or no treatment can be given.

I have read and understand the Scheduling/Financial Policy given to me by the Chiropractic Family Health Centre and Nova Health & Wellness. I understand that I am ultimately responsible for any services rendered to me by any and all licensed health care professionals at this office. Payment for services is not contingent upon my insurance coverage or settlement with a third party. I understand that if I terminate care outside of my doctor's recommendations, any balances will be due immediately.

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Guardian/Patient's Name, Printed

_____ _____

Guardian/Patient's Signature **Date**

_____ _____ / _____ / _____

(if minor) Print Child's Name **DOB**