Office Policy Form

It is our policy to receive payment at the time of service. IF this is a hardship on you, please call and make payment arrangements with our office prior to your appointment.

- For your convenience we accept cash, checks, debit cards, and credit cards
- If you would like a credit card on file for payments, we will keep all personal and financial information private.
- This office offers a time of service discount to our cash/ self pay/ no insurance patients.
- We will file insurance claims for you as a courtesy. Yor insurance contract is between you and your insurance company, Wilhelm Chiropractic, LLC does not guarantee that all services will be covered by your insurance company. All copays and non- covered amounts will be due at the time of service.
- If an insurance claim is not paid in 60 days we will be in contact with you. We ask that you stay in communication with our office and take action with your insurance company at that time
- If your insurance has not paid on a claim within 90 days, you will be notified and it will be your responsibility to pay the full amount. If the insurance pays on said claim, Wilhelm Chiropractic will refund you the full amount you paid on said claim.
- If you are going through a hardship time Wilhelm Chiropractic would be more than happy to help you set up a payment/hardship plan.
- Any accounts that have been unpaid for 90 days will start to acquire interest each month. After 120 days the claim will be sent to a third party collections agency.
- If you missed your appointment time or the appointment is canceled within 24 hours of appointment time, you will be charged a $15 fee.

Assignment of Insurance Benefits: “I hereby authorize my insurance company to pay directly to Wilhelm Chiropractic, LLC, benefits due me, if any, by reason of services described in the statement rendered.”

Release of Information: “I authorize Wilhelm Chiropractic, LLC to release my medical records to my insurance company and its agents; any information needed to determine these benefits or the benefits payable for related services.

Privacy Policy: “I certify that I have received and understand the privacy policy for Wilhelm Chiropractic, LLC.”

“By signing below I acknowledge that I have read, understood, and agree to the office/privacy/financial policy of Wilhelm Chiropractic. I also understand as the patient or legal guardian of the patient, I am ultimately responsible for any and all costs associated with treatment and care at Wilhelm Chiropractic, LLC.”

Signature of Guardian: _____ **Relation to Patient**:_____

Signature of Patient:_____ **Date**:_____

Witness:_____ **Date**:_____