CONNECT MOVEMENT CENTER
MOVEMENT AND COMPASSION FOR ALL

Financial Policy

Assignment of Benefits: I hereby assign payment directly to Connect Movement Center LLC, who represents this clinic to Payor Groups. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any cost incurred regarding collection of payment for services rendered.

Signature: _____ Date _____

Explanation of Insurance Coverage and Insurance Billing: We can file your insurance claims for you if you agree to your insurance company's fee schedule in advance to their payment. Your policy is a contract between you and your insurance carrier. You are ultimately responsible for payment which may include a co-pay, coinsurance and/or a deductible. If your claim is denied due to lack of coverage or your insurance company does not pay for the services rendered, you will be responsible for the entire balance on your account. Please be advised that all co-pays, payments towards deductible, and self-pay services are due at time of service. We accept Visa/Mastercard/Discover/American Express/Google Pay, checks and cash. A fee of $20 will be charged on all returned checks.

No-show/cancellation policy: We completely understand you may need to reschedule or cancel an appointment. Please contact our office at least 48 hours before your scheduled appointment to cancel/reschedule. A **No-Show fee of $40** may be charged if less than 24 hours' notice is provided. This fee is to help cover our costs. Our small business depends on our patients showing up and on time to their scheduled appointments. If you are 15 minutes late or greater, that will be counted as a "no-show". Please also consider other clients who may be waiting for an appointment. If there are 3 missed appointments with less than 24 hours' notice, you may not be allowed to be scheduled for a period. We will not consider emergencies or unforeseen events to be counted toward this 3-appointment policy.

Financial Responsibility: I agree to be personally and fully responsible for payment of services rendered in accordance with my insurance benefits (as outlined above) and for non-covered services. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney fees and collection expenses.

Signature_____ Date _____

Expectations In Our Clinic

The safety and wellbeing of our team and clients is very important. Please do not enter the clinic if you have been instructed to actively isolate/ quarantine by a health care provider or if you have a contagious illness. We also expect you to be respectful and appropriate to our clinicians, staff, and other clients. We reserve the right to refuse service to you if you behave otherwise or pose a danger to anyone in our facility.