Infinity Chiropractic and Wellness

Financial Policy and Patient Responsibility Agreement

1. Uniform Fee Schedule (Florida Law Compliance)

In accordance with Florida law, we maintain a uniform fee schedule. Charges for services are based on specific CPT codes and do not vary depending on insurance status or method of payment. A copy of our current fee schedule is available upon request and posted at the front desk.

2. Payment Responsibility

You are responsible for full payment of services rendered unless prior arrangements have been made. This includes any services not covered or denied by your insurance carrier. Payment is due at the time of service unless otherwise agreed upon in writing.

3. Insurance Filing (If Applicable)

As a courtesy, we may submit claims to your insurance provider. It is your responsibility to provide accurate and current insurance information. You are responsible for all co-pays, deductibles, co-insurance, and any non-covered services.

4. Non-Insurance (Wellness) Services

Certain services offered—such as massage, red light therapy, cupping, vibroacoustic therapy, and lifestyle education—are considered wellness services and not covered by insurance. These are self-pay only and require payment at the time of service.

5. Missed Appointments / Late Cancellations

Please provide at least 24 hours' notice for any appointment cancellations. Appointments canceled with less than 24 hours' notice may be subject to a cancellation fee.

6. Mobile Appointments

Mobile services require advanced scheduling and may incur additional setup or travel fees. Not all services are available via mobile visit. Availability will be discussed during appointment scheduling.

7. Accepted Payment Methods

We accept cash, major credit cards, debit cards, HSA/FSA cards, and mobile payment options. We do not accept post-dated checks or extend credit.

Acknowledgment and Agreement

I have read, understand, and agree to the financial policy outlined above. I understand that I am financially responsible for all services rendered, whether or not covered by insurance. I

agree to pay all co-pays, deductibles, and balances promptly. I have had the opportunity to ask questions and receive clarification.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____