



# SYNERGY Health & Wellness

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## OFFICE POLICIES

### METHOD OF PAYMENT:

Payment is due at the time of service. It is our office policy to collect 100% payment for any deductibles, co-pays, co-insurance and non-covered charges at EACH visit. We accept all forms of payment: CASH, PERSONAL CHECK\*, CREDIT/ DEBIT CARDS, FSA/HSA CARDS.

\* Returned checks will be subject to a \$25.00 collection charge in addition to the original check amount.

INITIALS \_\_\_\_\_

### FEE SCHEDULE:

Our office has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

- a) We are a participating provider in your health plan network.
- b) You are covered by a State or Federal program with a mandated fee schedule.
- c) You are a member of Preferred Chiropractic Doctor (PCD), or any other Discount Medical Plan Organization we may join. PCD is NOT an insurance company. Patients who are uninsured, or underinsured (have limited benefits for chiropractic care) may join PCD in our office or online and be entitled to network discounts similar to our insured patients. PCD is a nationwide membership program for patients that have no insurance or for those that wish to pay for services rendered at each visit. Membership is \$37.00 per year and covers you and your dependent family. This allows us to legally lower our fees while continuing to stay compliant with local and federal rules and guidelines. Members of PCD pay lower fees that are NOT REIMBURSABLE through insurance companies.
- d) Patients who are having financial difficulties may qualify for a reduction in a repayment plan or a financial adjustment on their account as detailed in our Hardship Policy and Application. They will be required to complete a financial form and include the necessary financial documentation to process their application.
- e) As part of our compliance program, our office will be unable to extend discounts other than those listed above.

We itemize every procedure so the charges per visit may vary. These charges depend on the individual needs of the patient. We will bill for all services rendered.

INITIALS \_\_\_\_\_

### HEALTH/MEDICAL INSURANCE:

You must provide us a copy of your health insurance card. If we are contracted with your insurance plan, we will submit your insurance claims. However, your insurance policy is an agreement between you and your insurance company. It is important that you understand your health benefits listed in your policy. There are many variations in insurance policies. Monitoring any policy limitations is considered the responsibility of the patient. As a courtesy to our patients, our office will attempt to verify coverage and benefits, BUT THIS IS NOT A GUARANTEE OF PAYMENT. Our office will do our best to ESTIMATE what your patient portion will be at each visit. You will be sent a statement for any difference in the amount paid at each visit and the actual amount due once your claims have been



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processed and paid. If your health plan determines a service “non-covered”, you will be responsible for the complete charge or balance of non-covered charge.

INITIALS \_\_\_\_\_

**EPAY STATEMENT ELECTION/AUTHORIZATION:**

For patient convenience, we offer E-Pay Statements. This allows the patient to pay a statement via a secure payment link sent via either text or email. To authorize E-Pay Statements, please mark your preferred delivery method:

Text      Cell Phone Number: \_\_\_\_\_

Email      Email Address: \_\_\_\_\_

I DO NOT Authorize E-Pay Statements. \*Statements will be mailed USPS

INITIALS \_\_\_\_\_

**MISSED APPOINTMENT POLICY:**

If you need to cancel or re-schedule an appointment, please allow us the courtesy of 24 hours notice so that we may schedule someone else in need at that time. If it is a continual problem there will be a \$20.00 charge added towards your account and the patient will be responsible for payment.

INITIALS \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date