TOLLAND FAMILY CHIROPRACTIC, LLC.
392 D Merrow Road Tolland, CT 06084 (860) 872-7771

Office Policy

We believe that a clear definition of our office policies will allow both you, the patient, and me, the doctor, to concentrate on the big issue – **REGAINING AND MAINTAINING YOUR HEALTH.**

APPOINTMENT POLICY

Multiple appointments have been scheduled, for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that count, and not what days they are.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to make up a missed appointment within **7 days** of any cancellation.

This office reserves the right to charge for missed appointments and those cancelled without 24 hours notice.

When entering the office on any given visit, please go directly to the front desk and "sign-in". We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to speak to the receptionist directly.

FINANCIAL POLICY

1. It is our policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments, regardless of whether or not this office accepts insurance assignment.
2. All payments are expected at the time of service. Patient's balances may not exceed **$150.00** at any time. If at any time your balance exceedes $150, your credit card on file can be automatically charged.
3. All insurance assignment patients must pay their deductible in full and the co-insurance at the time of service or at the end of each week. If insurance is denied, patient is responsible for that portion not covered.
4. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1 ½% per month.
5. All accounts not paid within 90 days will automatically be put through your personal credit card.

Please fill out your credit card information. Your card will not be used for any other purpose than for those stated above without your written consent.

Credit card: Mastercard ___ Visa____ American Express___ Discover___

Cardholder Name:____

Account number ________________________________ Exp. Date _________

Card holder signature:____

I have read the above policies and understand my responsibilities as they are stated.

PATIENT SIGNATURE________________________________Date: _____________