Alpine Chiropractic Center

833 W. Commercial Dr, Wasilla, AK 99654

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. To better serve your financial needs, our office offers several methods of payment. We are happy to answer any questions you have regarding our fees.

Patient Name:_____

_____**Cash/Check/Visa/Mastercard*:** Fees are to be paid at the time services are rendered unless special arrangements have been made in advance. We do offer a time of service discount to our patients who choose to pay in full at the time of their visit. If you choose to accept this discount, no insurance coordination or submittal will be provided by our office. *This discount requires that the payment be made on the same day as you are treated. Any service that is not paid for on the day of service is ineligible for this discount.*

_____**Private Insurance*:** As a courtesy to our patients, we accept assignment of insurance benefits after deductibles (if applicable) are met. Co-payments are due at time of service. We cannot bill your insurance company unless you provide your insurance information. Please be aware that some, and perhaps all, of the service provided may be non-covered charges or considered by your insurance company to be not medically necessary.

_____**Workers' Compensation*:** We will bill your employer's workers' compensation insurance company directly. You will need to provide all claim numbers and billing information within 3 days after your first appointment.

_____**Auto Accident*:** We will bill YOUR insurance company directly. You will need to provide all the claim numbers and billing information within 3 days after your first appointment. **WE DO NOT DO THIRD PARTY BILLING**.

Massage Policy

Please be considerate and make a reasonable effort to give us at least 24 hour notice if you must cancel or re-schedule. ***If you do not show up for your scheduled appointment, you will be subject to a $75 cancellation fee. Please note that this fee cannot be billed to insurance companies and must be paid by you personally***.

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

By signing below, I state that I understand and hereby agree to abide by these policies.

Signature:_____ Date:_____