arcadia health chiropractic
DR. CASSANDRA SEPULVEDA INC.

AHC OFFICE POLICIES & PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Arcadia Health Chiropractic for your health care needs. We are honored by your choice and are committed to providing you with the highest quality of care.
We ask that you take a moment to thoroughly read and sign this form to acknowledge your understanding of our office policies and financial agreement which are as follows:

FINANCIAL AGREEMENT

- The patient is ultimately fully responsible for the payment of all charges or fees for services provided, regardless of any contract of insurance, any action at the court, any settlement, structured settlement, verdict, or arbitration award which may be received or be due, or the course of outcome of any dispute regarding the same.
- The patient is aware that failure to pay for his/her treatment and care will result in the collection actions being taken to collect debt (i.e. being sent to collections agency)
- The patient is responsible for any costs associated with the collection of patient balances
- The office charges a $30 fee for non-sufficient funds for returned checks.
- PrePaid packages expire 12 months from the date of purchase and are non-refundable/non-transferable. Any remaining balance on your plan after this time can be credited towards regular visits at the current pricing schedule.

INITIAL _____

NEW PATIENT APPOINTMENTS
All new patient appointments require a $100 deposit to reserve your appointment. This deposit will then be applied to your first visit. Failure to cancel or reschedule this appointment with at least a 24 hour notice will result in a loss of this deposit.

INITIAL _____

SCHEDULING APPOINTMENTS
Please respect our time and let us know at least 24-hours in advance if it is necessary to reschedule your appointment – we may have other patients who would like to schedule an appointment during your original time slot. Our office staff usually sends appointment reminders whenever possible as a *courtesy*, however it remains ***your responsibility*** to remember your appointment day and time in event you do not receive a reminder.

INITIAL _____

LATE CANCELLATION/NO SHOW FEES
Failure to contact us at least 24 hours in advance to cancel/reschedule your appointment will result in the ***full cost*** of your appointment that will be due on your next visit. If you are under a pre-paid treatment plan, one visit will be deducted from your plan.

INITIAL _____

LATE APPOINTMENT ARRIVALS
If you are running more than ten minutes late to your appointment, please contact us as it may be possible that your office visit will be shorter than normal or need to be rescheduled. Dr. Sepulveda may be able to see you in the remaining time only if it does not compromise the quality of your care or another patient's appointment time.

INITIAL _____

I, (print name)_____understand and agree to the terms of this policy.

_____ _____
Signature **Date**