



# WHOLE HEALING CHIROPRACTIC & ACUPUNCTURE

Dr. Sydney Olson-Griess DC, DABCA

## **FINANCIAL POLICY**

We want to thank you for choosing our practice for Chiropractic care. We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our Financial Policy. Please contact the office if you have any questions or concerns.

### **PAYMENT IS EXPECTED AT THE TIME OF SERVICE:**

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Whole Healing Chiropractic & Acupuncture accepts cash, cashier's check, VISA, MasterCard, Discover, and American Express. There is a service charge of \$25.00 for returned checks.

*\*\*Collections: In the event that your account is forwarded to collections from WHOLE HEALING CHIROPRACTIC & ACUPUNCTURE, LLC, there will be a 10% charge of your balance for the expenses incurred by the agency. \*\**

### **PAYMENT PLAN & ACCOUNT BALANCE POLICY:**

Patients with an outstanding balance of 90 days or more must make arrangements for payment prior to scheduling appointments. If your account balance reaches \$350, we will require a payment toward your balance at each visit. If a payment cannot be made at the time of service, your appointment will need to be rescheduled until payment is possible. Once your balance reaches this amount, we will also need to discuss and establish a payment plan to keep your account in good standing.

### **CARD ON FILE POLICY**

Beginning January 2026, we will be implementing a Card on File Policy. A valid debit or credit card will be securely stored in your account and used in accordance with our Payment Plan and Account Balance Policy as well as our updated No-Show Fee Policy. Having a card on file allows us to simplify payments, reduce outstanding balances, and ensure smooth billing for all patients. Charges will only be processed as outlined in our financial policies, and you will be notified before any payment is applied.

### **REFUNDS:**

Patient/guarantor credits in amounts less than \$20.00 will be retained on account to be credited toward future balances unless a written request for a refund is received. Amounts \$20.00 and greater will automatically be refunded to the patient/guarantor.

### **INSURANCE:**

It is the patient's responsibility to provide their current insurance card and or referral at the time of service. If you fail to provide your current insurance/referral information, it may be necessary to reschedule your appointment. We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payments from your insurance company or if the payments are denied within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for being sure all charges are paid whether by you or by your insurance carrier. Please note your insurance plan determines your co pay/co-insurance/deductible; they also determine what codes they cover and do not cover. Your EOB (Explanation of Benefits) should outline this information. We do not bill third party insurance companies.



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## **MANAGED CARE:**

If you are enrolled in a managed care insurance plan (i.e., RPPG, HMO, etc.), you must receive a referral from your primary care physician before seeing a specialist. Retroactive referrals are not always guaranteed.

## **AUTOMOBILE ACCIDENTS/PERSONAL INJURY CLAIMS:**

Whole Healing Chiropractic & Acupuncture cannot get involved in third party liability; it is the insurance company's responsibility to determine damages. Patients shall be financially responsible for medical services related to an MVA and Personal Injury. It is also the patient's responsibility to notify Whole Healing Chiropractic & Acupuncture if the service is due to such incidents.

*\*\*We will need a claim number, adjustor's name, address, telephone and fax number and/or attorney information for personal injury or workers' compensation\*\**

## **DISABILITY /FMLA/INSURANCE FORMS:**

A \$25.00 flat fee, pre-payment will be charged for 3 or more pages. Please allow 7-10 business days for them to be completed.

By signing below, you acknowledge that you have received this notice and understand this policy.

\_\_\_\_\_  
Printed, Last Name, First

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature