

The Centered Body, PC
4350 Georgetown Square, Suite 705
Atlanta, GA 30338 770.936.9707

Financial/Payment Policy

Payment is expected at the time and date of service. We accept cash, personal checks*, MasterCard® and Visa®, for your convenience. If you have insurance, we will be glad to verify your coverage for you.

It is our earnest desire to get you well and back to full function as quickly and inexpensively as possible. In some cases where 1) chronic or 2) severely acute problems exist, however, it may take weeks or even months to achieve the goals we set together at the onset of chiropractic and ancillary care. Recognizing this, we want to make it as comfortable as possible for you to receive all the care that is necessary for you to achieve maximum relief and recovery.

If we are on your insurance/provider plan (In Network):

If your annual deductible has been met and we are on your insurance plan, we will gladly accept your designated co-pay at time of service. If your annual deductible has not been met, we will expect payment in full at the time of service(s) until such time as your deductible has been met. At that time we will accept your co-pay at time of service. Your specific co-pay is determined by your plan; this amount can usually be found on the front of your insurance card. Most plans run \$10 to \$30, or 10% to 50%, for co-payment amounts.

If we are not on your plan (Out of Network):

If your annual deductible has been met and we are not on your designated insurance plan, your insurance may pay anywhere from 40% to 90% of all charges deemed medically necessary. Each insurance plan is different; your specific coverage limits will need to be verified. If your annual deductible has not been met, we will expect payment in full at the time of service(s) until such time as your deductible has been met. At that time we will accept your percent co-pay (10% to 60%) at time of service.

AUTHORIZATION FOR RELEASE OF INFORMATION – I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS – I hereby authorize payment directly to this practice of benefits otherwise payable to me, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this agreement.

GUARANTEE OF ACCOUNT – For services furnished by The Centered Body, PC I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Georgia and agree to pay, if necessary, all costs of collection, including attorney's fees.

CANCELLATION POLICY – Appointments that are cancelled with less than a 24-hour notice are subject to a charge. The No-Show fee for Chiropractic Services is \$20. The No-Show Fee for Massage Therapy is \$75. Please note that insurance carriers will not cover this cost.

Date

Print Name

Witness

Signature

* We are delighted to accept your personal check as payment for any/all services in our offices. Please note, however, that should your check be returned to us by your bank for insufficient funds, we will pass along to you all charges levied (min. \$25) by our bank in conjunction with the transaction in question.