ALTERNATIVE HEALING CHIROPRACTIC CENTER
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576 Donnelly Ave, Coos Bay, Or 97420
Telephone: 541-266-7543 Fax: 541-269-9408

Written Financial Policy

Thank you for choosing **Alternative Healing Chiropractic Center**. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, VISA, MasterCard®, American Express®, Discover Card® or CareCredit® Healthcare
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note: **Alternative Healing Chiropractic Center requires payment at the time of service.**

For plans requiring multiple appointments, alternative payment arrangements may be provided using Care Credit.

For patients with insurance we are happy to work with your carrier to maximize your benefit and provide you with the documentation you need to receive reimbursement for your treatment.

Medicare will issue all reimbursement checks directly to the patient.

We require 24-hour advanced notice for cancellations. Our answering machine takes messages 24 hours per day. A fee is charged for missed or same day cancellations; $25 for chiropractic appointments and/or half the cost for massage appointments.

Alternative Healing Chiropractic Center charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

Signature on file: I authorize the use of this form on all of my insurance submissions to be used in lieu of my signature. I authorized release of information to all of my insurance companies for the purpose of normal billing procedures. I authorize the doctor and her staff to act as my agent in helping me to obtain payment from my insurance company. I permit a copy of this form to be used in place of the original.

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Patient, Parent or Guardian Signature Date

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Patient Name (Please Print)

[1]Subject to credit approval