1700 Northside Dr. Ste A3
ATLANTA GA 30318
(404)351 1800

Financial and Cancellation Policy

Initials: _____ I am aware that **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED** to me in the form of check, cash, money order, Visa, MasterCard, Discover, or American Express unless otherwise stated by the office. I am aware that there is a fee for returned checks of $55 to cover office/personnel time and bank fees.

Initials: _____ I understand that Back to Basics submits claims to my insurance, if accepted, on my behalf as a courtesy to me, the patient, and that I am responsible for any uncollected amounts. I also understand that it is my responsibility to update Back to Basics on any policy or personal information changes that I have while my treatment with them is active.

Initials: _____ I understand that in the event of missing payments, overdue accounts, etc. an interest fee that will not exceed the legal limit per day will be added to my account on top of what is already owed. I understand that if my outstanding bill becomes more than 90 days overdue Back to Basics can turn my account over to an outside collection agency. The collection agency fees will be added to my account balance as well at that time. I also understand that the aforementioned statement is not the only means that Back to Basics is allowed to collect money on my outstanding account.

Initials: _____ I understand that in the event that I am not responsible for my bill that the individual that is responsible is aware of this financial policy and will be upheld to the same standards and I will provide contact information for the said individual so that they may receive a copy of this Financial Policy.

Initials: _____ **COURTESY TEXT/EMAIL REMINDERS** I understand that I will receive an "opt in" message to get reminders for my appointments. I can opt out at any time on my own by text or email. I understand that this is a courtesy of the office and that there may be technical difficulties as with any technology. In the event that a reminder is not received, I understand that I am still responsible for keeping my appointment.

Initials: _____ **CANCELLATION POLICY** 24 hour notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged the full amount of your appointment since we will not be able to hold any third party payer liable. This amount must be paid prior to your next scheduled appointment. The cancellation fees are as follows:

$60: Chiropractic	**$100: 30min Massage and Chiropractic**
$50: 30min Massage	**$130: 60min Massage and Chiropractic**
$90: 60min Massage	**$175: 90min Massage and Chiropractic**

The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you, and if you do not keep the schedule then other patients who need "same day" urgent visits, or earlier appointments than the schedule permits, are being obligated to wait longer than necessary. Obviously, acute health problems and family crises are expected. Cancellations of convenience or last minute schedule conflict will be your responsibility. We remain available to discuss this policy in general, or individual circumstances. Thank you for understanding.

I _____ on this _____ day of _____, 20_____ have read carefully and agree to the terms listed above in the Financial policy of Back to Basics.

_____ _____

Patient Signature *Date*