Innate Empowerment Corporation

KB Chiropractic
40 Boulevard
Kingston, NY 12401

phone: 845.331.8010
fax: 845.331.8961

Fee For Service Qualification

KB Chiropractic Office Policies

1. Our fees for service are the same for all patients, whether or not they are covered by insurance, except in the case of a hardship.
2. All payments are expected at the time of service or by the last visit of each week. No patient balance may ever exceed $150.00 at any given time.
3. Whether cash or insurance patient, it is your understanding that anything insurance does not cover becomes patient responsibility.
4. In the event that you discontinue care prior to the doctor's recommendation, you are responsible to pay in full any outstanding balances within 10 business days.
5. If you are unable to keep an appointment for any reason, we require that you provide us with at least 24 hours notice. Emergencies, of course, are an exception.
6. We require that you sign-in at the front desk upon arrival at each visit as we attempt to honor all appointments at their scheduled times. If you arrive late or early, you may have to wait for the next available appointment time.
7. We reserve the right to charge $25.00 for missed appointments without prior notification.
8. If you are seeking maximum health benefits from chiropractic care in our office, we recommend that you follow the doctor's treatment plan.

We request that you sign this form as verification that you have read, understand and agree to comply with this policy.

Fee For Service Patients: I understand that ultimately I am financially responsible for the professional service rendered. I understand that I will receive a treatment plan that states the commitment required for the doctor to treat said condition(s). I also understand that this is a contract between KB Chiropractic and I; I have read the policies listed above and understand those policies.

Patient/Legal Guardian: _____ Date: _____

Insured Patients: I understand that this office verified my insurance benefits as a courtesy to me and that it is not a guarantee of benefits. I also understand that the quoted information does not release me from any financial responsibility to this office and that I am responsible for denial of benefits.

Patient/Legal Guardian: _____ Date: _____