

**Arons Chiropractic, Inc.**

Scott S. Arons, D.C. \* 2050 Main Street \* Red Bluff, CA 96080

Phone: (530) 527-0121 Fax: (530) 527-0179

**Financial Policy**

**Initial Visit, Insured:**

Your first visit consists of an examination and treatment. If you would like your charges submitted to your insurance company, we will submit the claim for you. Your financial responsibility will depend on several criteria including:

1. Specific treatment you receive
2. Your chiropractic benefits through your insurance carrier
3. Any deductibles and/or co-payments required by your insurance carrier

In many cases there is no way for us to know your financial responsibility until we receive the processing from your insurance carrier. Our policy is to collect \$25.00 prior to your exam. If your carrier processes the claim and shows a lesser amount due by you, we will either refund any overpayments or apply them to subsequent treatments. Any amount due over the \$25.00 collected will be billed to you and due upon receipt.

**Subsequent Visits, Insured:**

Subsequent visits are billed to your insurance carrier and are subject to the same conditions that are mentioned above. If we are able to determine a standard co-pay, that amount will be collected prior to each visit. If we are unable to determine a standard co-pay, we will collect \$7.00 prior to each visit. Overpayments will be reimbursed or applied to further treatments while outstanding balances will be billed to you and due upon receipt.

**Cash Patients:**

If you do not have insurance or you do not want your charges submitted to your insurance carrier for any reason, we do offer a "Cash Price".

Initial Exam and Treatment: \$55.00

Subsequent Treatments: \$32.00 per visit

**Massage Therapy**

We proudly offer massage therapy by appointment. If massage is a benefit of your insurance policy we will bill it for you. For those without the benefit, you may pay our standard cash price of \$25.00 for 30 minutes or \$40.00 for 60 minutes. We also offer Gift Certificates for this service.

"My signature below indicates I have read and understand the Financial Policy. I acknowledge that I am financially responsible for all services that I receive."

\_\_\_\_\_  
Patient/Guardian's Signature

\_\_\_\_\_  
Date