WELLCARE
CHIROPRACTIC CENTER

230 Lowell Street, Wilmington, MA 01887
(978) 658-7700 □ (978) 658-7703 fax

NON-INSURANCE FINANCIAL POLICY / RECEIPT OF HIPPAA PRIVACY NOTICE

Financial Policy Assignment

We believe a clear understanding of our *Financial Policy* will allow us both to better concentrate on the big issue, ***regaining and maintaining your health***.

Therefore, it is agreed between us, that payment will be made in full at the time services are rendered or, if a pre-payment plan has been purchased, made prior to agreed treatment. It is also understood that the office policy of Wellcare Chiropractic Center (WCC) mandates that your balance may not exceed $100.00.

I understand this financial policy fully, and hereby agree that if I should terminate care for any reason, my outstanding balance becomes due and payable immediately. I also understand that my account must be kept current in order for WCC services to be continued.

IMPORTANT: While we understand that obstacles occur that can take you away from your appointment, please remember we ask for a minimum 12 hours cancellation notice. Missed chiropractic appointments or cancellations made less than 12 hours will incur a **$40 missed appointment fee**.

I have read and understand this policy.

Member Name (please print)	Member Signature	Date

Guardian Signature (if patient is under 18)	Relationship to Patient	Date

---

Receipt of Privacy Notice (HIPPAA)

I have read, understand and agree to what is stated in both pages of the Wellcare Chiropractic Center, Inc. Privacy Notice, as acknowledged below by my signature.

Member Signature	Date

Parent/Guardian Signature *(if patient is under age 18)*	Date