WELLCARE
CHIROPRACTIC CENTER

230 Lowell Street, Wilmington, MA 01887

(978) 658-7700 • (978) 658-7703 fax

NON-INSURANCE FINANCIAL POLICY & RECEIPT OF PRIVACY NOTICE (HIPPAA)

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 appointments or cancellations made less than 12 hours will incur a $35 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

To expedite said payment, unless other arrangements are made, I agree to authorize WCC to use the following credit card *(we will notify you before taking this action)*:

My credit card is a: ( ) Visa ( ) Mastercard Card #:_____

Authorized Signature:_____ Expiration 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