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 time, personnel time and any fees that Back to Basics' bank might charge.

Initials: _______ I understand that Back to Basics submits claims to my insurance 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 I cannot pay an outstanding bill I have the right to set up a payment plan with Back to Basics that will conclude within 4 months of my first date of treatment and will be required to sign and hold true to the terms of a Hardship Agreement. I understand that if I am shown to be in violation of the aforementioned Hardship Agreement that I will be immediately subject to the Back to Basics Collection Process.

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, but is not limited to; turn my account over to an outside collection agency. The collection agency fees will be added to my account 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: _______ **CANCELLATION POLICY** This office has a policy of charging a fee for missing an appointment or canceling with less than 24 hours' notice. We will not be able to hold any third party payer liable for your absence, so we will have to charge you the full amount of the visit. The cancellation fees are as follows:

$60: Chiropractic	$90: 30min Massage and Chiropractic
$45: 30min Massage	$110: 60min Massage and Chiropractic
$80: 60min Massage	$150: 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*