Life Enhancement Clinic, P.C. – Financial & Clinic Policies

Please read each section and check the square after reading each section. Please sign and date the bottom of this form.

I understand that the policy of Life Enhancement Clinic, P.C. requires payment in full for all services rendered at the time of my office visit, unless other arrangements have been made. If co-payment is required this will be collected at each visit and I understand I will receive a statement for the non-covered portion of what was billed to my insurance provider. □

I understand that it is my responsibility to be aware of my insurance coverage benefits for chiropractic care. I understand it is my responsibility to be aware of my deductible and co-insurance policies. □

I understand that health and accident insurance are an arrangement between my insurance carrier and me. I authorize Life Enhancement Clinic, P.C. to release any information to process insurance claims. However, I clearly understand and agree that I am ultimately responsible for payment of my account. □

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will become immediately due and payable. □

I understand that regardless of my payment method, any nutritional supplements, supplies, equipment or educational materials I purchase must be paid for in full. These items will not be charged to my account and there is no refund for opened or used products. Unopened or unused products that have not expired, nor are within 60 days of expiration, may be returned for a credit. □

I understand that some services provided at Life Enhancement Clinic, P.C. are not covered by my insurance provider. These include, but are not limited to, nutritional consultations, blood tests, saliva tests, hormone testing, stool tests, functional medicine evaluation, lifestyle coaching, wellness care or the like. I understand that I am responsible for any non-covered care. I understand that Life Enhancement Clinic, P.C. will not bill insurance on my behalf for functional medicine or clinical nutrition services. □

I understand that my appointments (office, phone or e-mail consultations) are established to seek professional medical advice. I understand appointments for services other than chiropractic care or rehabilitation are not submitted to my insurance provider based on the nature of the complaint. I understand that there is a $35 charge per 10 minutes of the doctor's time. Lab fees are established and current pricing is available upon request. □

I understand that phone consults, e-mail questions, or other forms of contact that require a chart review, in depth response, or need for further evaluation will accrue a minimal fee. Simple questions that do not require a review of your personal records, etc will not be charged. □

I understand that my appointments and treatment plan scheduling reserves a block of time for me to adequately receive the necessary services. In the event I need to reschedule I understand a 24 hour notice is appreciated. □

I understand that it is important to keep my scheduled appointment and I should arrive a few minutes early to ensure I can be taken to a treatment room at my scheduled appointment time. I understand that the Life Enhancement Clinic, P.C. reserves the right to reschedule my appointment, or place me on a waiting list, if my tardiness would interrupt the rest of the scheduled patients. □

Typical Appointment Times With Physician	
Chiropractic adjustment for established care plan	5-10 minutes
Chiropractic adjustment with rehabilitation	15-20 minutes
Re-examination / New Injury Work-Up	30 minutes
Clinical Nutrition Consults	10-30 minutes

(Clinical nutrition consults are scheduled in 15 minute slots which generally accommodate most patients' needs. If you need more (or less) time, please notify the Front Desk when scheduling future appointments.)

I understand that not all of my questions may be answered at every visit due to time constraints and I may need to schedule additional time to fully address these issues. □

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(Signature of Patient) (Date)