Allied Chiropractic

Dr. Edward Wilkinson, D.C.
3347 Duke Street
Alexandria, VA 22314
(703) 823-1414

OFFICE POLICY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Allied Chiropractic will prepare the necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Allied Chiropractic and/or Dr. Edward Wilkinson, D.C. will be credited to my account upon receipt. I, hereby, authorize Allied Chiropractic to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me will be charged directly to my account and that **I am personally responsible for payment.** I also understand that if I suspend or terminate care at this office, any unpaid fees for professional services rendered to me will be immediately due and payable. Furthermore, I understand that if my monthly billing statement is not paid within (30) days, Allied Chiropractic will charge interest on the unpaid balance of one and one-half percent (1.5%) per month due after thirty days and that will be added to my bill. Should my account ever go into default and it becomes necessary for Allied Chiropractic and/or Dr. Edward Wilkinson, D.C. to institute legal proceedings to recover the amount due, I agree to pay all court costs and attorney's fees of thirty-three and one-third percent ($33\ ^1/_3\%$) connected with such legal proceedings.

I understand and agree that the amount paid to Allied Chiropractic for X-rays is for examination only and the X-ray negatives will remain the property of Allied Chiropractic, being on file where they may be seen at any time with twenty-four (24) hours notice, while a patient of this office. I also understand and agree that I may request copies of my X-rays for a nominal charge of ten dollars ($10) per sheet in advance of the films being copied. I also agree that I will be responsible for all additional expenses incurred by Allied Chiropractic on my behalf in relation to the treatment of my condition. I also agree that Allied Chiropractic, Dr. Edward Wilkinson, D.C., its medical and/or professional staff will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis produced.

I also understand that if I am not able to keep a scheduled appointment, I am to notify Allied Chiropractic at least twenty-four (24) hours in advance. All no call/no show missed appointments and last minute cancellations will be billed directly to me (**not** my insurance company) at twenty-five dollars ($25) per missed office visit. I understand that in an effort to comply with managed care guidelines, any time I cancel/reschedule three (3) times during my initial care plan I will not be given another appointment. Allied Chiropractic at its discretion and considering all circumstances **may** continue to see me on a time and space available basis.

☐ I am eligible for MEDICARE/MEDICAID benefits, and I will present my insurance card to the receptionist **before** receiving treatment at this office.

☐ I am not eligible for MEDICARE/MEDICAID benefits.

I hereby authorize Allied Chiropractic and its medical and professional staff to treat my condition as deemed appropriate and utilize chiropractic procedures and manipulation throughout my spine. This office does not participate with any insurance plan that utilizes American Chiropractic Network (ACN) or American Specialty Network (ASN).

Patient Signature: _____ Date: _____