Dr. Pam Wilson
Healing Bodies. Changing Lives.

FINANCIAL POLICY FOR CASH AND PRIMARY INSURANCE

130 Maple Ave., Suite 7A
Red Bank, NJ 07701
Phone: 732-842-7004
Fax: 732-842-8799

Patient Name (print): _____

Thank you for choosing Dr. Pamela Wilson as your health care provider. The following is our financial policy, please read it carefully, initial and sign.

FINANCIAL POLICY

Please present photo ID and insurance card(s) at your initial check-in.

Payment is due prior to services being rendered.

We are an out-of-network (OON) provider for all primary health insurance carriers. As a courtesy to our patients who have OON insurance coverage, we will bill your insurance company for each visit.

Please note the following:

The cost of the first visit is **$435.00** This includes the assessment call, and Dr Wilson's preparation time prior to the first visit.

As the patient you will be required to pay your "time of service payment" (TOSP) at the beginning of each office visit. If you do not have insurance, have not yet met your deductible, or your insurance does not cover chiropractic care, the TOSP for a standard office visit is **$155.00**. For patients with OON coverage, a reduced TOSP will be determined by what the insurance support is once the deductable has been met.

If insurance payments are sent to the patient or the policy holder rather than our office, you will be required to forward these payments to Dr. Wilson's office. If we do not receive payments sent to you from your insurance company, the patient becomes immediately responsible for the balance of the billed amount, less the TOSP.

If for any reason you terminate care and treatment, any fees for professional services rendered to you will be immediately due and payable based upon this financial policy.

You will be billed **$50.00 for any returned check**.

If you fail to show up for a scheduled appointment and/or do not notify us at least 24 business hours prior to your scheduled appointment, you will be billed for the full amount of that missed appointment according to our customary fees.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or responsible party **Date**