Red Cedar Chiropractic Payment Policy

We strive to provide the highest quality healthcare while maintaining affordability. We understand that even with insurance, most patients experience at least some out of pocket expense. To help ease this burden, we offer the six payment plans listed below. If you have any questions or concerns, please feel free to ask.

Please initial your selection:

________ ***Plan 1***: Full payment at time of service with 20% discount. Cash, check, Visa and Mastercard accepted.
You may still submit your receipt to your insurance company for reimbursement or application to any deductible.

________ ***Plan 2***: This is a workman's comp case.

________ ***Plan 3***: Third party liability case. Complete billing info below.

Name:____Phone: ___________________________

Address: ____

________ ***Plan 4***: Medicare / Medicaid. *Co-pays and deductibles are due at the time of service*

________ ***Plan 5***: Billed to insurance: *Co-pays and deductibles are due at the time of service*

________ ***Plan 6:*** Payment plan over time. Interest free as long as payments are kept current. No discounts apply.

________ ***Plan 7:*** CareCredit. Patient payment plans that allow you to pay over time with convenient low minimum monthly payments. There are 6 and 12 month no interest plans. Ask front desk for information.

Plans 3-6 require a Visa or Mastercard on file with this office to guarantee full payment of your balance.
We will NOT charge the card unless it becomes the only way to collect what is due. Once a claim is processed we will direct bill you by mail for any balance. If the billing attempts are repeatedly ignored, then, and only then, will the card be charged.

Visa ___ MC ____ CARDHOLDER NAME: ____

CARD: #_______________________________________ EXP. DATE ______________ V# _____________(3 digit # on back)

I have read, understand and agree to the payment policy of Red Cedar Chiropractic. I understand that I am responsible for all costs of my chiropractic care, regardless of insurance coverage and have selected the payment plan initialed above. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand all balances are due within 30 days and that interest on overdue accounts is charged at 10% annually. I understand that I am responsible for all collection fees, court costs and reasonable attorney fees to collect unpaid accounts.

If I have left a credit card number, I authorize Red Cedar Chiropractic to bill my card under the terms stated above.

If I have listed an insurance carrier, I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care.

Print Patient Name: ________________________________ Print Guardian name: _________________________

Patient or Guardian's Signature____Date_____________