Restorative Health Center
Policy – Effective December, 2015

Appointments

Restorative Health Center offers a range of Health and Wellness service and products, on a ***by appointment*** basis. Hours for appointments are every half hour, starting:
Tuesday from **10am** through **6pm** with 5:45pm being the last appointment of the day
Wednesday from **10am** through **3pm** by appointment only.
Thursday from **10am** through **6pm** with 5:45pm being the last appointment of the day

Services

A comprehensive list of services and pricing can be found at the front desk. The fee for one 15-minute chiropractic adjustment is **$55.** Additional procedures (such as infrared mat, cranial adjustments, laser and taping, etc.) carry additional fees, due upon checkout.

Payment

Payment is due at the time of services rendered. Restorative Health Center accepts cash, personal checks, and Visa/MasterCard/American Express.

Insurance

Restorative Health Center accepts **auto accident and worker's compensation insurance**. Additional information must be provided in a timely manner in order to accept this insurance. Your coverage must first be verified; until such coverage is verified and all additional forms are submitted, you will be expected to pay the regular rate of **$55** per office visit.

All other patients will be required to pay the regular rate of **$55** per office visit. Patients are responsible for submitting a receipt for services rendered to their insurance company if they wish to receive reimbursement for Chiropractic and Wellness care provided by Dr. Carter. Restorative Health Center will aid in this process by providing Patients with accurate, dated, and ICD10 coded receipts and will provide any additional information that the insurance company may request. It is, again, the Patient's responsibility to facilitate this process, and the patient must allow time for the records to be printed/emailed. Requesting receipts early and often is the best way to stay on track, and create an accurate portrayal of the Patient's care to their insurance company.

Name: ______________________________ Date: __________