ALTERNATIVE MEDICINE FAMILY CARE CENTER
2050 40th Avenue
Suite 2
Vero Beach, FL 32960
(772) 778-8877
(FAX) 778-9509

Financial policy

Thank you for choosing us as your health care provider. We are committed to your successful treatment. Please understand that payment for your care is considered an important and inseparable part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Additionally, due to individualized responses and the nature of medicine, I have not been given any guarantee of results or outcome regarding my condition.

All patients must complete our "Patient Intake Form" before receiving treatment from the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS, HSA CREDIT CARDS.

HEALTH INSURANCE

As a courtesy, we will call your insurance company to determine if you have benefits for our services. If you have benefits, you will be responsible for filing the claim with your insurance company. After each treatment, we will provide you with a form containing all the necessary information for your insurance company to process your claim. Your insurance company will reimburse you directly.

We will be happy to provide you with some guidelines for filing with your insurance company. However, the final responsibility for filing, tracking, and collecting on your claim rests solely with you.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor's guidelines and commit to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. A photocopy of this form shall be considered as effective as the original.

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

X_____ Date_____
Signature of Patient or Responsible Party