WILSON CENTER
AT THE CORE OF WELLNESS

WILSON PHYSICAL MEDICINE, LLC

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

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

FINANCIAL POLICY

1. Payment for your first day's services is due at the *completion* of your office visit.

2. At the completion of your first office visit you will schedule your second appointment. At your second visit, Dr. Wilson (chiropractor) will inform you as to your examination results and whether or not you would benefit from chiropractic care. If not, the appropriate referral will be made. In addition, we will discuss your insurance coverage and any other financial matters.

   Please note the following:

   a. Although we are an out-of-network provider for all insurance carriers, excluding Medicare, as a courtesy to our patients we will bill your insurance company and wait for their estimated payment. As the patient you will be required to pay your "time of service" payment at the beginning of each office visit. If the insurance company does not pay within 45 days (requirement by law), we will contact the insurance company and attempt to understand/correct the reason/problem for non-payment. If we do not receive payment in a timely manner from your insurance company, you will be immediately responsible for the set "cash fee for service" based upon the office fees at the time of the service. As a courtesy, we will provide you with information for the dates-of-service in question so you may pursue payment directly from the insurance company if you so desire.
   b. If you do not have insurance or if your insurance does not cover chiropractic care, we require your cash "time of service fee" payment in full at the beginning of each visit.
   c. If for any reason you terminate care and treatment, any fees for professional services rendered to you will be immediately due and payable.
   d. If you fail to show up for a scheduled appointment and/or do not notify us that you cannot make this appointment within 24 business hours of your scheduled visit, you will incur a $50.00 missed appointment fee.

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

_____ **Date:** _____
Signature of Patient or responsible party

Certain services provided by Dr. Wilson at Wilson Physical Medicine, LLC are not reimbursable by Medicare. The charges for these services will be your responsibility as per Medicare Guidelines and explained in the Advanced Beneficiary Agreement (ABN)

I understand that certain services are not reimbursable by Medicare and that I will pay for such services as rendered.

_____ **Date:** _____
Signature of Patient or responsible party