Lethbridge Chiropractic
Dr. Brandon Workman D.C. 122A 5 St. S, Lethbridge, AB
Phone: 403-524-2929 • Fax: 403-524-51-5794 • www.Lethbridgechiropractic.

FINANCIAL POLICY

1) We accept cash, debit card, Visa and MasterCard.
2) All payments are due at the time of service, unless special arrangements have been agreed upon prior to visit.
3) As a courtesy to our patients, we will bill your insurance company for you (if allowed by your company). Please keep in mind that if there is a discrepancy, we will let you know as soon as possible; however, we will not get involved with any dispute between you and your insurance carrier.
4) If you have a credit balance, we will reimburse you after payment has been received.
5) All supplements/vitamins, lab work, supports and other supplies **must** be paid for at the time they are received.
6) You are responsible for timely payment of your account.

Workers Compensation Claims

Dr. Workman does not accept Workers Compensation cases.

Personal Injury/Motor Vehicle Accidents

1) Personal injury and auto accident cases will be billed to your auto insurance company, providing that a claim has been filed, approved and the appropriate paper work has been done.

Please Initial that you have read the following statements and agree:

1. _____ I hereby authorize Dr. Brandon Workman to provide Chiropractic Services for me.

2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Lethbridge Chiropractic.
3. _____ All payments are due at the time of service, unless special arrangements have been agreed upon prior to your visit.
4. _____ I understand that if I have any prosthetics or surgical implants (including breat implants, an artificial joint etc.) I should discuss this with the doctor because it may effect care.
5. _____I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Lethbridge Chiropractic reserves the right to terminate a doctor-patient relationship if a patient **is continually unable to comply with reasonable treatment plans.**
6. _____I agree to provide Lethbridge Chiropractic with 24 hours notice if I need to cancel or change an appointment. I understand that if I fail to provide this notice on 3 or more occasions, Lethbridge Chiropractic reserves the right **to terminate a doctor-patient relationship.**

I have read, understand and agree with the above financial policy.

Patient/Guardian Signature **Date**

Updated 4/07