

Megan Hudson, D.C.
52 Maple Street
Florence MA 01062
413.695.2738

OFFICE POLICIES AND PATIENT CARE FINANCIAL AGREEMENT - Confidential

We would like you to have a clear understanding of our policy concerning payment and insurance. Our office accepts cash, check, Visa, Mastercard, and Debit cards. As a courtesy, we do offer payment plans. Please ask at the desk.

The standard fee for the initial office visit is \$160 and follow-up appointments are \$80. If you pay at the time of service, the discounted rate for the initial office visit is \$140 and the follow-up is \$70. Additional services will incur additional charges. The fee for a bounced check is \$15. Appointments missed or canceled without at least 2 hours notice are charged \$40 with exceptions.

Note for insurance patients: Appointments may include craniosacral therapy and/or techniques utilized through a chiropractic neurology approach. These are not covered benefits with health insurance carriers and are the patient's responsibility.

If you have **no insurance**, please pay in full at the time of service.

If you have **insurance**:

1. On each visit, you will need to pay the portion of your charges not covered by your insurance. This amount will depend on your coverage and may include copayments, deductibles, co-insurance, craniosacral therapy, or non-covered services. The required amount the patient owes must be paid at the time of treatment as a condition to receive treatment unless a prior arrangement has been agreed upon.
2. We do not promise that your insurance will pay. Any amount not paid by your insurance will be the responsibility of the patient.
3. If you have a PPO, you may have Out Of Network coverage. We are willing to do the billing for you, however, please be aware that the difference between cost of service and insurance payment is the patient's ultimate responsibility.
4. Medicare patients are responsible for paying a yearly deductible of \$131 which may be covered by secondary insurance.
5. **Amounts over thirty (30) days from notice to the patient will incur a late fee of \$25 and be charged to your credit card with advance notice given.**

NOTE: Bills for services or products are ultimately the patient's responsibility.

I hereby authorize Dr. Margaret Hudson or her agents/employees to bill my credit card for amounts unpaid by insurance as specified above. Please alert me before doing so.

Print name as it appears on credit card: _____ Exp date: _____

Credit card number: _____ M/C or Visa I elect not to give credit card info

Signature: _____ Name: _____