DESIGNED MOVE
CHIROPRACTIC & SPORTS REHABILITATION
Aaron Rickelman, DC MS & Abbi Rickelman, DC MS
1210 NW 18th St., Suite 110
Ankeny, IA 50023
Phone: 515-957-4042
Fax: 515-598-7855

Financial Agreement

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully. If you have any questions, do not hesitate to ask.

Appointments

1. We value the time we have set aside to see and treat you. For this reason, it is our intent to not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice prior to your scheduled appointment. Failure to do so could result in cancellation fees.
2. If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3. Missed appointments will be subject to cancellation fees.
4. We strive to minimize any wait time; however, emergencies do occur and will take priority over scheduled visits. We appreciate your understanding.

Financial Responsibility

1. According to your treatment plan, you are responsible for all balances accrued.
2. The patient has three months to make a payment on accrued/accruing balance. If no payment has been made on a balance after 3 months, the physician has the right to file the responsible party to a collection agency. The financially responsible party of the account will be subject to fees associated with the collection agency and legal services.
3. We accept cash, checks, debit cards, or Visa and MasterCard credit cards.
4. In the event of a missed appointment not cancelled at least 24 hours in advance a fee of $25.00 will apply. A $40 fee will be charged for any checks returned for insufficient funds.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name:_____ Date:_____

Patient Signature:_____

Parent/Guardian Name:_____ Date:_____
(If patient is under 18 years of age)

Parent/Guardian Signature:_____