# FRANCIS CHIROPRACTIC CLINIC AND WELLNESS CENTER

## FINANCIAL POLICY/SIGNATURE ON FILE

**_____INSURANCE/MEDICARE/MEDICARE ADVANTAGE PLANS/MEDICAID**

- □ I authorize use of this form on all of my insurance submissions.
- □ I authorize release of information to all my Insurance Companies.
- □ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies
- □ I authorize payment direct to my doctor.

If you have insurance that covers chiropractic services, we will bill your primary and secondary insurance companies as a courtesy to you. Please remember, your insurance policy is a contract between you and your insurance company. You are responsible for the portion that your insurance policy may not cover at the time of services rendered. Specifically:

**YOU ARE RESPONSIBLE FOR YOUR INSURANCE DEDUCTIBLE.** Your deductible is the amount of money that your insurance policy requires you to pay before the insurance company will begin to pay your claims.

**YOU ARE RESPONSIBLE FOR YOUR CO-PAYMENT.** Your co-payment is the amount determined by your insurance company that is due for each office visit. This should be paid at the time services are rendered. NOTE: You MAY also owe co-insurance.

**YOU ARE RESPONSIBLE FOR YOUR CO-INSURANCE.** Your co-insurance is the amount of money remaining after the insurance has paid its portion of your charges. Again, you MAY have a co-payment AND co-insurance.

**YOU ARE RESPONSIBLE FOR PAYMENT IF YOUR INSURANCE COMPANY DEEMS YOUR TREATMENT NOT MEDICALLY NECESSARY OR IF YOUR TREATMENT IS A <u>NON-COVERED SERVICE.</u>**

**_____ UNINSURED CASH PATIENT**

This plan means that ALL FEES are to be paid at the time services are rendered on EACH date of service.

**_____CARE PACKAGE**

This is offered to patients who either do not have insurance coverage or to patients who choose not to send to insurance. You purchase a package of five visits at a discounted rate. This amount is paid on the first date of service and this fee will cover five regular adjustments. For a NEW PATIENT there will also be a nominal exam fee added to the package. If x-rays are needed, the charge for the x-rays taken will be an additional fee.

This is a non-refundable package which can be shared with family members, however a new patient would have the exam fee added. The package does not expire and the price is subject to change annually.

**_____PERSONAL INJURY**

If you are involved in an accident or other personal injury, we will provide all necessary information to the insurance company, your attorney, or other third party. You will receive a monthly statement describing the month's charges added to your account. Each case in this category is unique. Sometimes personal or auto insurance is billed while your case is in litigation. Some accounts are left unpaid until litigation is complete. Ultimately, YOU ARE RESPONSIBLE FOR YOUR CHARGES AND ARE REQUIRED TO MAKE A $50.00 MONTHLY PAYMENT UNTIL YOUR CASE IS SETTLED.

**_____WORKER'S COMPENSATION**

If you have been injured while at work, this is classified as a Worker's Compensation injury. Please bring a form authorizing treatment signed by your employer or we will provide you with a blank form that must be completed and signed by your employer and returned to us within 7 days. Once authorization has been received, we will send all bills to your employer's Worker's Compensation carrier. Please remember the Worker's Compensation insurance is a contract between you, your employer, and your employer's carrier, NOT the doctor. **YOU ARE RESPONSIBLE FOR YOUR BILL IF WORKER'S COMPENSATION DENIES YOUR CLAIMED INJURY.**

I have read and agree to the financial policy for the type of account I have checked, and I understand **I am responsible for my bill.** I understand that I can change my account type at a future date. I permit a copy of this authorization to be used in place of the original.

_____

Patient Name (Please Print)

_____ _____

Patient /Guardian Signature Date

July 2013
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