Petersen Chiropractic Center, PC - Financial Policy

Thank you for choosing Petersen Chiropractic Center PC as part of your health care team. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bills is considered part of your treatment. Please read, initial after each section and sign at the bottom prior to your treatment.

It is our office policy to collect 100% payment for any deductibles, co-pays, co-insurance and non-covered charges at EACH visit. We accept as forms of payment: CASH, PERSONAL CHECK*, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and CARE CREDIT. *Returned checks will be subject to a $25.00 collection charge in addition to the original check amount. INITIALS _____

HEALTH/MEDICAL INSURANCE: You must provide us a copy of your health insurance card. We will submit your primary/preferred insurance claims as a courtesy to you. However, your insurance policy is an agreement between you and your insurance company, not between your insurance company and this clinic. It is important that you understand your health and accident benefits listed in your policy. There are many variations in insurance policies. It would be in your best interest for you to call your insurance company to determine your CHIROPRACTIC benefits. Monitoring any policy limitations is considered the responsibility of the patient. As a courtesy to our patients, our office will also attempt to contact your insurance company to verify coverage and benefits, BUT this is not a guarantee of what the insurance company will pay. Our office will do our best to ESTIMATE what your patient portion will be at each visit. You will be sent a statement for any difference in the amount paid at each visit and the actual amount due once your claims have been processed and paid. If your insurance company fails to process a claim for any reason you will be required to pay for services and seek reimbursement from your insurance company. INITIALS _____

AUTOMOBILE ACCIDENT: You must provide us a copy of your auto insurance information and a copy of the police report of the accident. If you are receiving treatment for injuries sustained in an automobile accident, your med pay on YOUR auto insurance is the primary carrier. This means that we will promptly submit claims to and await payment from YOUR auto insurance company. We will not bill a third party for initial payment of your claims. If an attorney is handling your case, please notify the insurance department right away. If your insurance company does not pay your claims within 30 days of submission you will be required to pay for services and seek reimbursement from your insurance company. INITIALS _____

WORKERS COMP: If you are receiving treatment for injuries sustained while on the job you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. We cannot bill your health insurance company for treatment received as a result of injuries sustained while working for your employer. If your or your employer do not provide this information, if claims are not paid within 30 days of submission, or if you suspend or terminate care you will be required to pay for services rendered. INITIALS _____

NON-COVERED EXPENSES: Our office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are directly responsible for payment of medical supplies. You may be responsible for payment of charges reduced or denied due to the insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance does not cover due to limitations of your policy, or what they consider reasonable and necessary or deem to be experimental or investigational. It is your responsibility to know what the policy limitations are. Our goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, and not on what your policy limitations are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses. INITIALS _____

SPECIAL FORMS: The completion of disability and other special request forms, such as those for supplemental accident policies, is time consuming and may take up to 14 days to complete. There is a $50.00 charge for the completion of these forms. INITIALS _____

MEDICAL RECORDS REQUESTS: If we referred you to another physician for consultation or continued care, we will forward your records to that physician if necessary. If you or an insurance agent want copies of your records for any other reason, there is a fee of $0.50 per page. Please allow up to 14 days for the request to be completed. INITIALS _____

MISSED APPOINTMENT POLICY: Attending your scheduled appointments is crucial to successful treatment of your condition. If you need to cancel or reschedule an appointment, please allow us the courtesy of 24 hours' notice so that we may schedule someone else in need at that time. If you fail to give notice or if you do not show up for your appointment you will be charged a fee of $25.00. INITIALS _____

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

_____ _____

Patient Signature* Date

*Parent or Guardian must sign if patient is under 18 years of age.

Petersen Chiropractic Center, PC - Assignment of Benefits

Name of Insured (please print): _____

Insureds Date of Birth: _____

I hereby assign all insurance benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health insurance/medical plan, to issue payment(s) directly to **Petersen Chiropractic Center PC** for health care services rendered to myself and/or my dependents. I understand that I am responsible for any amounts not covered by insurance.

I hereby authorize **Petersen Chiropractic Center, PC** to: 1) Release any information necessary to insurance carriers regarding my condition and treatments; 2) To process insurance claims generated in the course of examination or treatment; and 3) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have read, understand, and agree to **Petersen Chiropractic Center, PC**'s Financial Policy. I understand that any charges not covered by my insurance company, as well as any applicable deductibles, co-insurance and co-payments are my responsibility. All professional services rendered are charged to the patient and are due at the time-of-service, unless other arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payments.

I have requested health care services from Petersen Chiropractic Center, PC on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon request. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature* Date

_____

Relationship to Patient

_____ _____

Witness Date

*Parent or Guardian must sign if patient is under 18 years of age.