Financial Policy

Updated November 2016

Major Medical

With a copy of your driver's license and your insurance card we will attempt to get a coverage estimate for you. **This is not a guarantee of coverage, and you will be responsible for any services not covered by your insurance company regardless of the reason for denial.**

- **You are fully responsible for any services your company does not pay, regardless of the reason. Accepting services when rendered implies that you personally agree to be financially responsible for those services.**
- Benefit quotes are not a guarantees of benefits.
- If your policy changes or terminates you must immediately notify us to ensure proper billing and avoid extra charges.
- Know your visit limits or maximums. We cannot always predict what insurance companies bundle or count as a visit. Ask us to check if you are unsure.
- You will typically receive Explanation of Benefits (EOB;s) sooner than we do, If you see a billing issue do not ignore it, please ask about it. This may save you money in the long run.
- We have the capacity to process Primary insurances only. We will collect deductibles and co-pays/coinsurances that correlate to primary insurance benefits only. Should you have a second insurance you should call them about coordination of benefits or send them your EOB's and receipts as you get them.

Medicare

Medicare currently only covers the manipulation portion of chiropractic at 80%.You may have a second insurance to help with the remainder. You must pay for exams, x-rays, and therapies received. We will provide you with the closest estimate of those expenses as they occur. You are responsible for services rendered, and submitting to a service implies that you accept responsibility for the charges associated. Please ask if you are unsure as to an items associated charge. TOS discounts do not apply to Medicare services. **You must inform Medicare** of any secondary or supplemental insurance to ensure crossover of

Non-Insurance (Cash)

For patients without insurance we may offer you a **Time of Service discount**. We extend this same courtesy to insurance companies, however they never pay the same day of treatment! The minimum service fee for any visit regardless of services performed is $45. No ICD10 Coding or Claim generation is done for TOS cases. No Exceptions!

Nutrition services are not eligible for discounts.

Massage Services. Massage service can sometimes be (partially) billed to an insurance company when medically necessary. Surcharges may apply to non-medically necessary portions of the massage process. Cancellation fees apply.

Disclosure of Fee's

Examinations:

99202	Expanded History and Exam	$110.00
99204	Comprehensive History and Exam	$240.00
Radiology:		
72040	Cervical radiographs (3 views)	$ 60.00
72050	Cervical radiographs (5 views)	$ 80.00
72100	Lumbar radiographs (2 views)	$ 60.00
Therapy:		
98940	Manipulation (1-2 areas)	$ 40.00
98941	Manipulation (3-5 areas)	$ 60.00
97010	Ice/Heat therapy	$ 7.00
97014	Muscle Electro-stimulation	$ 16.00
97035	Ultrasound	$ 20.00
97012	Traction	$ 30.00
97110	Therapeutic exercises	$ 40.00
97140	Manual Therapy	$ 40.00
97112	Neuromuscular reeducation	$ 40.00
97124	Massage Therapy-per hour	$136.00
97810	Acupuncture -per session single insertion	$ 70.00

*fees for non-listed services disclosed upon request. Prices subject to change without re-notification.

I have read the related disclosures and understand the cost of my care at HealthMatters Chiropractic. I agree that I am solely responsible for payment of all of expenses related to my care. Furthermore, I promise to pay any and all collection, court, and attorney fee's for the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the described fee schedule regardless of the outcome of my case. I understand that HealthMatters Chiropractic charges fees (currently 22% APR compounded monthly) on accounts requiring billing or those 90 days or more past due.

There is a $ 35 fee on all returned checks.

Signature (guardian if under 18): _____ Date:_____

Assignment and Instructions for Payment

Notification of Dr.'s Lien:

I fully understand that I am directly and fully responsible to said doctor or clinic for all medical bills submitted for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And **I further understand that such payment is not contingent on any acceptance, settlement, judgment, or verdict** by which I may eventually recover said fee. **I understand that Verification of Insurance Benefits is not a guarantee of coverage**, as stated by any and all insurance companies, and I am ultimately responsible for the full charges incurred at HealthMatters Chiropractic Health Clinic regardless of the denial reason from my insurance company. **I understand that it is my responsibility to ensure my insurance company pays for all necessary medical care** from HealthMatters Chiropractic and that **by continuing care I am implying that I agree to, and am benefiting from, all prescribed care**. I acknowledge that I have been given the opportunity to present HealthMatters Chiropractic with a copy of my plan booklet prior to care and ask questions regarding my financial obligations.

I understand that should funds be paid to me directly that are intended to compensate for unpaid medical expenses at HealthMatters Chiropractic, I will immediately reimburse HealthMatters Chiropractic their portion of the payment. I understand that failure to do so will result in immediate penalties being levied at a rate of no less than 22% APR (calculated monthly, retroactive to the first day of treatment), and the addition of any and all expenses related to the collection of said debt. I understand that HealthMatters Chiropractic has the right to report any unpaid bills to a credit reporting agency or refer unpaid bills to collections services.

I also agree to promptly notify said clinic of any changes in insurance plans or coverage, or changes in representation by attorneys, or claim status. I understand that failure to do so will result in my immediately becoming responsible for the account. I also understand that I am responsible for any uncollected debt in the event of denial of claims associated with billing disputes arising from changes in benefits (companies, levels of coverage, or processing of claims).

Please Note

If applicable, I hereby instruct and direct any and all Insurance Companies or Attorneys involved in this case to which I have claim for medical expenses, whether stated individually or not, to pay directly by check HealthMatters Chiropractic for any and all payments for medical services rendered by HealthMatters Chiropractic, its doctors or associates, regardless of the nature of the payment or the association between the claimant and the policy holder, as soon as such payments are generated or received.

I instruct my attorney to pay directly to HealthMatters on my behalf any PIP funds immediately as they are received for services rendered. I instruct any 3rd Party Company or legal counsel to pay directly when possible money owed to HealthMatters in the course of settling my medical bill claims.

This is a direct assignment of my rights and benefits as a claimant on this policy for the professional or chiropractic expense/benefits allowable and otherwise payable to me.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above any insurance payments.

I also authorize the release of any information pertinent to my case to any Insurance Company, Adjuster, or Attorney involved in this case, as set forth under the guidelines of HIPAA. A photo-copy of this Assignment shall be considered as effective and valid as the original.

By signing below I acknowledge that I have read and understand my financial obligations. Furthermore, I accept and agree to all contingencies contained within.

Dated at HealthMatters Chiropractic this _____day of _____ 2017.

Received by Staff: Initials _____

_____ _____

Patient Name (print): Witness or Notary if required

Signature of Claimant or Policyholder or guardian if minor