Financial Policy

Patient Name: _____ **Date of Birth:** _____

Basic Policy Pay for service is due in full at the time service is provided in our office.

For Patients with Insurance We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at time of service.

Medicare Patients We do not accept medicare assignment. As a courtesy, we will bill Medicare and your supplement for you. Medicare will only allow for spinal manipulation and will limit these services based on medical necessity. Medicare does not cover any therapy, supports, supplements, examinations or x-rays done in this office. Most often, your supplemental insurance will only cover what medicare allows. You should receive reimbursement from both in approximately 4 - 6 weeks.

Non Covered Services Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Workers Compensation If your injury is work related, we will need the case number and carrier name prior to your visits in order to verify authorization, and bill the workers' compensation insurance company

Personal Injury Cases We will bill for auto accident or other liability or lawsuit related cases provided all information is obtained prior to treatment. This includes the insurance carrier information, accident report (if available) attorney information (if applicable), and other information relative to filing an insurance claim. We accept liens on an individual basis, and at the Doctor's discretion.

Missed Appointments In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel massage appointments. If proper notice is not given, you may be charged for missed appointments.

Medicare Patients; Signature of File: I request payment of authorized Medicare benefits be made either to me or on my behalf to _____ for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine thsese benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claims forms, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare non-assigned cases, the provider does not agree to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for all services.

Patient's Name (Please Print) _____

Patient's Signature _____

Patient's Medicare No: _____

Assignment of Insurance Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to ***SANDS CHIROPRACTIC CLINIC*** . This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood, and agreed to the above financial policy for payment of professional fees.

Signature: _____ **Date:** _____