Financial Policy Account #_____

Patient Name_____ Date_____ DOB:_____/_____/_____

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy (FP), which we require you read and sign prior to any treatment. The purpose of our FP is to keep *health care cost down*! All patients must complete and sign our entrance forms and FP before seeing the doctor.

Please read the section that pertains to your billing status.

Insurance

Our office will provide you with an EZ Insurance Verification form that you can complete on the phone or the internet to know what your chiropractic benefits are. It is your responsibility to complete and return the EZ form on your next visit. If you prefer our office to call your insurance carrier there is a $15.00 forms fee. We may accept assignment of insurance benefits; however, if an exam is completed, we request you pay $30.00 towards your exam at the conclusion of your first visit. We cannot bill your insurance company unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Thus, if a referral/authorization is required it is important that you obtain one from your Primary Care Physician/or plan. If you wish to have this office file your insurance claims for you, we will require you to pay the insurance policy deductible and the patient's percentage and or co-pay as stated in your policy. If unsure of co-pay we will request you to pay $30.00 per visit until the specific co-pay amount has been provided. If your insurance company denies your claim, the balance will automatically be transferred to your responsibility.

If you are considered a "dependent" under the provisions of your insurance policy and are not personally responsible for payment of your bill, please have the policy holder(s) read and sign the financial policy.

Please be aware that some and perhaps all of the services provided may not be covered and/or not considered reasonable by your insurance policy. Regarding insurance plans where we are participating provider, all co-pays and deductibles are due at the time of treatment. In the event, that your insurance coverage changes to a plan where we are not a participating provider, refer to the paragraph regarding "Cash" patients.

I acknowledge that although I have assigned insurance benefits to this office, it is probable, that my insurance plan will not pay for all charges incurred or the coverage will be less than the amount incurred. I acknowledge that I am responsible for any charges refused or discounted by my insurance company. Further, I will pay for any collections or legal charges incurred in the collection of these uncovered charges should I fail to pay them upon request. I acknowledge that it is my responsibility to pay the balance of my bill once insurance benefits have been received.

Patient Initials X_____

Secondary Insurance

We will bill secondary insurance companies. Any amount due after your primary carrier has paid will be submitted to your secondary insurance; however, any deductibles are your responsibility.

Durable Medical Equipment: Items must be paid for at the time of service. See "Durable Medical Supply/Equipment" policy statement. We do not allow any returns on durable medical supplies and/or equipment. These will not be billed to your insurance company. You are responsible for payment. An itemized billing statement can be provided for the patient to submit to his/her insurance company for reimbursement.

Usual and Customary/Non-Covered Services

Usual & Customary Fees: our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Durable Medical Supplies/Equipment: Refer to the "Durable Medical Policy Statement.: You will be asked to sign the DME policy statement for any supplies and/or equipment you receive (i.e. any patient receiving electrical muscle stimulation will be receiving therapy electrodes at a cost of $12 each pair). These will not be billed to your insurance company. You are responsible for payment. An itemized billing statement can be provided for the patient to submit to his/her insurance company for reimbursement.

Account #_____

Patient Name_____ DOB:_____/_____/_____

Cash Patients

FSRC offers Value Plans. This program is designed to help us improve your health and save you money.

Medicare, MediGold, Anthem Senior Advantage & other non-traditional Medicare plans

1. Medicare guidelines indicate that the only service **covered is a manual spinal manipulation.**
2. If you have a required co-payment listed on your card we will collect it at each visit.
3. **Examinations and Physical Therapies are not covered under these plans.**
4. **Medicare requires that an examination be performed by the chiropractor.** Since you are a new patient, our examination cost today is between **$80.00 and $115.00.**

Medicaid and Medicaid Managed Care Plans (MCP)

1. **Our clinic is a provider for the traditional Medical Card only.**
2. **We are not providers for any Anthem, CareSource, Molina or any other MCP. We are not authorized to bill them on your behalf. Therefore, you will be responsible for any charges incurred today.**
3. **Medicaid pays for 30 visits only within a 365 day period for children under the age of 21; 15 visits within a 365 day period for adults older than age 21. You will be responsible for any visits that exceed this allowed amount.**
4. We must have your current monthly medical card on file in order to render treatment. You will be financially responsible for any denied services that reflect a lapse in coverage.
5. No coverage is available through the Ohio Medicaid Disability Assistance Card or any other program sponsored by the Ohio Department of Human Services. You are responsible for payment of services.

Missed Appointments

If you fail to show up (no show) for your appointments, we reserve the right to charge you for your appointment. You may incur a $30.00 charge for failure to call and change or cancel your appointment. Please help us serve you better by keeping your scheduled appointments or at least call us when you cannot keep your appointment.

Missed Payments and Miscellaneous Fees

Missed payments must be paid in addition to your next scheduled payment. We accept: Cash, Personal Checks, Visa/MasterCard, American Express or Discover.

- **Interest:** 10% of the balance if not paid in full within 45 days of the current statement date.
- **Return Check Fee:** $25.00
- **Forms (per form):** $15.00 allow 3 business days
- **Collection Fee:** $25.00

I understand and accept the policy regarding insurance assignments and the Health Insurance/Cash/Medicare/Medicaid policy statement. I have received a copy of the policy statement and the fee schedule. If I discontinue care without the doctor's authorization, the balance of my account is due and payable immediately.

Further, I will pay for any collections or legal charges incurred in the collection of these uncovered charges should I fail to pay them upon request.

Patient's Signature X_____ Date X_____

Guarantor's Signature X_____ Date X_____