Osteopathy Chicago, LTD.

Dr. Dane J. Shepherd, D.O.

Payment and Office Policy Agreement

Welcome to Our Practice!

Thank you for choosing us as one of your healthcare providers. We are committed to providing you with quality and affordable health care. Below are our office and financial policies. Please read it, ask us any questions you may have, and sign it in the space provided.

Given the constant changes in insurance company payment policies, the following in-office policies have been established to help us continue to provide patients with the best quality medical care.

Financial Terms

1. PAYMENT is expected at the time of your visit. We only accept checks.

2. RETURNED CHECKS will incur a $37.00 service charge. You will be asked to bring cash, certified check or a money order to cover the amount of the returned check plus the $37.00 service charge to pay the unpaid balance prior to receiving services from Dr. Dane J. Shepherd, D.O.

3. INSURANCE: I understand that Dr. Dane J. Shepherd, D.O. is not in network with any insurance plans including private insurance or government insurance such as Medicare or Medicaid. For those patients who are members of health care plans, we do not accept any insurance as a basis for payment. Payment in full is due at the time of visit. This office will submit a claim to the patient's insurance carrier for those patients who have insurance carriers that allow out of network providers to bill as a service to their patients with some exceptions listed below, but please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. Our office cannot guarantee that your carrier will pay your claim. Our office does not submit a claim to any secondary insurance plan or any plan if the patient is covered under Medicare or Medicaid. Our office does not submit a claim to the patient’s health care insurance plan if the claim is related to employment, auto accident, or other accident.

4. CANCELLATIONS OR MISSED APPOINTMENTS: I understand that when I make an appointment, I am reserving space in Dr. Dane J. Shepherd, D.O.’s schedule that is no longer available to other patients. If you need to cancel or change a scheduled appointment, we ask that you provide the office with notice at least 72 hours in advance of your scheduled appointment time. Patients who miss their appointments, or who do not provide 72 hours advance notice of the cancellation will be charged the full office fee of $280.00 which is due in full before your next scheduled visit.

5. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Osteopathy Chicago, Ltd. for all office visit charges incurred.

MEDICARE AND MEDICAID. I understand that Dr. Dane Shepherd, D.O. is not a provider for Medicare and Medicaid. I understand that this office does not bill Medicare and Medicaid for any services. All services are expected to be paid in full at the time of service. I am not currently eligible for Medicare or Medicaid. I will notify Dr. Dane J. Shepherd, D.O. in writing immediately if I become eligible for these payors. By signing below, I state that I am not eligible for Medicaid or Medicare and will never ask this office to bill them.

RELEASE OF INFORMATION: I hereby authorize and direct Dr. Dane Shepherd, D.O. and Osteopathy Chicago, Ltd. to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

DIVORCED PARENTS of PATIENTS OR GUARDIANS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

ACKNOLEDGEMENT AND AGREEMENT
In consideration of medical treatment to be received, I **do not** hereby assign and transfer over to Osteopathy Chicago, LTD all of my rights, title, and interest in any health insurance policies that are filed on my behalf to the extent benefits are available. I understand that I am financially responsible for all charges.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_______________________________________ ______________
Signature of Patient (or Guarantor, if applicable) Date

_______________________________________ ______________
Please Print the Name of the Patient Date