COASTLINE HEALTH & CHIROPRACTIC

Julio C. Fassino, D.C.
CEO/Chiropractor
CA License 19111

Patient Financial Agreement

General Financial Policy (Please initial each)

___ **Payment for private pay fees, deductible, co-insurance, or co-pay is due on the day of your visit.**
___ A credit card, Flex Spending Account card, or Health Savings Account card is required and will be stored in a safe encrypted file on your account. If payment is due, we will apply it to the card. This prevents payment delays and streamlines visits.
___ Private pay fees can be supplied to you upon request. These fees are subject to change, yet rarely, without prior notice to keep in step with inflation and increases in business overhead.

Insurance Billing Policy (Please initial each)

___ As a courtesy, health insurance claims may be sent on your behalf. We will only submit insurance claims for policies that have chiropractic benefits. We do not guarantee insurance reimbursement for your visits.
___ We will charge for any additional administrative tasks outside of submitting claims. We will not participate in insurance appeals, pre-certification or post-certification requests for any reason unless we are contractually obligated by participating networks.
___ To eliminate delays, payment for our services will be charged to the credit cards on file, at monthly intervals, For unpaid insurance claims.
___ We recommend verifying your own policy benefits by calling the member support phone number on the reverse side of your insurance card. Ask for both in and out of network coverage. You may also verify your coverage through the insurance member's portal on their website. **We are not responsible for verifying your insurance.**

Personal Injury Policy (Please initial each, if applicable)

___ Personal injury cases that require 3rd party payers for payment must have health insurance coverage with chiropractic benefits, and/or medical benefits on their car insurance, and/or retained a personal injury attorney with a signed lien. We reserve the right to accept or deny your case or to work on a lien basis or not.
___ Accepting to work on a lien does not imply, in any manner, that our fees are contingent on the outcome of your case settlement. We expect to be paid in full for all services rendered. We expect payment to settle your account balance and lien immediately once funds have been released to you and your attorney. However, we agree to only wait for payment to settle your account balance and lien for 1-year post termination of care.
___ We require that you provide us with a copy of the police report, attorney contact information, car insurance information of all parties, a copy of your auto insurance card, and the policy declaration page.

Acknowledgments (Please select all that apply)

___ I, the undersigned, am a **non-insured self-paying patient**. I understand and agree to the financial policy as stated above. I authorize the use of this signature on all bank card purchases related to my care including services, products, supplements, and therapeutic devices.
___ I, the undersigned, am an **insured patient**. I understand and agree to the financial policy as stated above. I assign directly to Dr. Fassino and/or his associate doctors, all medical benefits, if any, otherwise payable to me for services rendered. I further agree to provide you all endorsed insurance checks with the explanation of benefits mailed to me for claims submitted for services performed by either Dr. Fassino or his associate doctors at Coastline Health & Chiropractic. I understand that I am responsible for all charges whether they are paid by the insurance company. I hereby authorize the doctor(s) to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions and bank card purchases related to my care including services, products, supplements, and therapeutic devices.
___ I, the undersigned, was involved in a **personal injury**. I understand and agree to the financial policy as stated above. I authorize the use of this signature on all bank card purchases related to my care including services, products, supplements, and therapeutic devices.

Patient Name: _____

Patient Signature: _____ Date: _____