FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week, if you sign a credit guarantee form. We offer a 20% Time of Service Discount of billable charges if balances are paid in full the week they are rendered. We are happy to accept your check credit card. Also, we have "Care Financing Plans" with 0% interest for up 6 months. Ask to find out how to qualify.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. <u>You</u> may then submit the bill to your insurance carrier for reimbursement. SECONDARY INSURANCE, please inform us of any secondary insurance you may have.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please either answer or bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay in full for your care and we will submit reports whenever necessary.
2. We will bill from the Med Pay/Liability portion of your auto insurance.
3. With a signed Letter of Protection, Assignment & Lien form, we will send bills & reports to your attorney and await payment at the time of settlement for up 6 months after release from care with a credit guarantee on file.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 months after your care is completed if you do NOT have an attorney under 2 conditions (1) the insurance company agrees to accept assignment & pay our office directly, and (2) you have a current credit guarantee on file. Our office will wait up to 6 months after release from care if you have an attorney and have a credit guarantee on file. Once the claim is settled, or if you suspend or terminate care, any fees are due immediately

MANAGED CARE PLANS

- ☐ You are required to pay a $___________ co-pay at the time of service.
- ☐ A referral from your primary care physician will be necessary. Out of network benefits are available if a referral is not obtained.
- ☐ Benefits are available for up to ______visits per year. A $______co-pay is due at the time of service.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS
Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

RETURNED CHECKS
The charge for a returned check is $40 paid by cash or money order.

NO SHOW POLICY | EXTENDED HOURS
I agree to pay $35 for a missed appointment for chiropractic and/or massages, holiday, extended hours or Saturday appointments. Chiropractic extended hours, weekend appointments and holiday appointments are available if the doctor is in town. Extended hours are subject to additional charges which **are not** covered by insurance carriers. These charges are in addition to the services rendered and the patient is solely responsible for their payment.

_______________ Initial to accept

MINOR POLICY | BILL TO RESPONSIBLE PARTY:
Children under the age of 18 may not be guarantors for their medical bills. This office is not a party to your divorce decree. The responsibility for minor rests with the **accompanying initial** parent.

_______________ Initial to accept

COLLECTIONS
All over due accounts are given 90 days to pay their bills. After 2 statements are sent and 2 phone calls are made, these accounts will be turned over to either an attorney or collection agency. In the event that your account is turned over for collections, the patient (guarantors/responsible party) agrees to pay the collection fee in addition to any finance charges accessed to collect on the debt.

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _______________________________________, do here by designate Kenya M. Gaskin, D.C. and/or Gaskin Family Chiropractic (hereafter referred to as “my doctor”, to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan with respect to any medical or other healthcare expense(s) incurred as a result of the services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain record, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the services I received from my doctor. I have read and understand the payment policy of Gaskin Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Gaskin Family Chiropractic and my insurance company. I request that Gaskin Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Gaskin Family Chiropractic that fees will be due and payable immediately.

Assignment of Benefits I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Gaskin Family Chiropractic, P.C./ Kenya M. Gaskin, D.C. Release of Information I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.

Payment Agreement I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

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Patient’s signature (or guardian if patient is a minor) Date Witness Date