

FINANCIAL POLICY

Do you have a Flex Plan/Medical Savings Account/or Health Savings Account? Yes or No

All patients fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it pertains to you.

CASH/SELF-PAY/ TIME OF SERVICE DISCOUNT

For non-covered services, payment is due at the time of service, or at the beginning of your care via Cash, check or credit/debit card. Balances over 30 days are subject to a service charge. Refunds for packages or credit balances will be refunded upon request, less the full current rate of the services, and expire one year from date purchased, unless otherwise noted.

HEALTH INSURANCE

Greco Family Chiropractic provides its services directly to you, not your insurance company. You are ultimately liable for your bill. We will verify your benefits & coverage, however the benefits represented to us by your insurance company are not a guarantee of payment. As a service to our patients, we will submit your bills to your insurance company. All co-pays/co-insurances are due at the time of service. You are responsible for asking your primary doctor for your own referral. You must provide us with all of your insurance cards because your own insurance is always primary and your spouse's secondary, and Medicaid is always payor of last resort. Inaccurate information will cause insurance denial, or recouping payments, leaving you responsible for self-pay rates.

WORKER'S COMPENSATION

"On the job" injuries may be covered by your employer's Workers' Compensation insurance.

1) Immediately notify your employer in writing of the accident and ask for instructions. 2. Obtain the name, address, phone number, adjuster and claim number for your employer's Workers Compensation insurance company and notify them that you are treating at our office. 3. Notify our office of the injury and fill out the necessary paperwork for a worker's compensation case. 4. Your employer/work comp insurance may require that you treat with their panel of work comp doctors for the 1st 90 days.

AUTO ACCIDENT/PERSONAL INJURY

Automobile or other accidents may be covered by your auto or other insurance policy. Please inform our office immediately if you are in an accident. The necessary paperwork must be filled out completely and to the best of your knowledge. You must furnish our office with your insurance company name, claim number, adjuster's name and phone number. Please provide us with any attorney info and ask them to fax us their letter of representation and any requests for records. We cannot carry balances, so once your coverage is exhausted, your health insurance can usually be billed, or we accept self pay.

MEDICARE

We accept assignment for Medicare, meaning they pay us direct. Most insurances only cover what they consider Medically Necessary, and may deny at any time, without warning. Patients are responsible for copays, coinsurances, deductibles and self-pay pricing for denied, non-covered, uncovered services. Your working aged spouse's insurance may be primary to your Medicare.

I have read and understand the financial policy of GRECO FAMILY CHIROPRACTIC. In the event my insurance company does not pay the charges I have incurred at this office, I agree to pay any and all fees accumulated within 90 days of the date of service.

Patient Printed Name

Patient or Parent/Guardian Signature

Date

Patient Billing Acknowledgement Form of Non-covered Services

Under your health plan, you are financially responsible for co-payments, co-insurance balances, and deductibles for covered services. In addition to these payments, you are also financially responsible **FOR ALL NON-COVERED SERVICES DEFINED BY YOUR HEALTH PLAN CONTRACT**. For example, this may include items and services such as supplies/products, therapeutic activities, doctor consultations, **AS WELL AS care that is determined to be maintenance/elective, or care that exceeds your benefit limits.**

While treating for a chronic condition, you may **elect** to receive care beyond that which is determined to be medically necessary. You may also choose to receive **maintenance** care once the maximum benefit from treatment has been reached. **Maintenance/Elective Care** is defined as treatment that does NOT significantly improve a clinical condition. If, during the course of your maintenance/elective care, you develop a new condition– or a previous condition becomes significantly worse– your care may no longer be considered as maintenance/elective and may be covered by your health plan again. Your provider must submit a request for additional insurance coverage.

Please understand that this form is not a notice of denied coverage from your insurance company. However, it is your acknowledgement that if the products or services submitted to your insurance company are denied, you are financially responsible for the full or remaining balance.

The services or products listed below may not be covered according to your health plan. Your signature at the bottom of the document indicates that you understand this information and that you agree to pay our “Time of Service” prices for the listed services or products.

Services that may be provided during your treatment process:

- | | |
|--|--|
| <input checked="" type="checkbox"/> New Patient Consultation - \$75 | <input checked="" type="checkbox"/> X-rays - \$40 |
| <input checked="" type="checkbox"/> Kids New Patient Consultation - \$40 | <input checked="" type="checkbox"/> Chiropractic Manipulative Therapy - \$40 |
| <input checked="" type="checkbox"/> Re-evaluation Office Visit - \$20 | |
|
 | |
| <input checked="" type="checkbox"/> Therapies - \$10/session | |
| – Cold Laser Therapy | – Posture Pump |
| – Intersegmental Roller or Cervical Traction | – Hydrotherapy |
| – Muscle Stimulation with Heat/Ice | |
| <input checked="" type="checkbox"/> Custom Orthotics - \$299 | <input checked="" type="checkbox"/> Massage Therapy - \$65/hour *8-hour |
| <input checked="" type="checkbox"/> Cervical Support Pillow - \$55 | cancellation fee |

Patient Signature: _____

Date: _____