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 Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

I hereby acknowledge that I received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA (found hanging at front desk, and on website), and understand that this office's HIPAA Compliance Manual is available upon request.

I also consent to the use of my health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

_____ _____ _____

Patient Printed Name Patient or Parent/Guardian Signature Date

I also consent to the release of my health records to the undernamed family members. Records include, but not limited to, billing statements, insurance inquiries, appointments, and condition diagnoses.

List individuals' names here: Relationship to you:

_____ _____

_____ _____

_____ _____

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X-RAY RELEASE

All Patients Please Read and Sign:

I, _____ (Print Name), do hereby give my consent to Greco Family Chiropractic and its representatives to take X-Rays as deemed appropriate by the examining Doctor of Chiropractic.

I also hereby declare that to my knowledge; I am NOT PREGNANT.

_____ _____

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 **maintainance** 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:

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

Patient Signature: _____ Date: _____

A. Notifier: Greco Family Chiropractic, 144 York Rd, Warminster, PA 18974, 215-675-8009

B. Patient Name: _____ C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. Spinal Manipulation, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. Maintenance Care below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Maintenance care: Spinal Manipulation	Medicare does not consider "maintenance," "prevention," or "wellness care" to be medically necessary.	**$40**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Spinal Manipulation** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Spinal Manipulation** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Spinal Manipulation** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D. Spinal Manipulation** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may also ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel that you have been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.