**All Natural Chiropractic Financial Policy**

Welcome to **All Natural Chiropractic**. Our goal is to provide our patients with the best possible care and to maintain a good physician-patient relationship. We believe that these objectives are best achieved when our patients are clearly informed of our financial policy. Please review this policy carefully. We encourage patients to freely communicate with our office and to review any questions with our staff.

**Billing and Payment**

This office accepts cash, checks and the following credit cards: **MasterCard, Visa and Discover**.

As a courtesy, we will submit bills to your insurance if you are covered by a plan in which we participate. You will be required to sign an Assignment of Benefits as a condition to our billing your insurance. However, the Assignment of Benefits does not cancel your financial obligation to this office. Full payment is due at the time of service for uninsured patients; for patients who are covered by a plan in which our office participates but services are not covered; or for patients who are insured by a plan in which this office does not participate.

You may pay full payment is due at the time of service. We will not bill insurance but will provide you with a standard form itemized bill so that you may submit the charges to your insurance or health plan for reimbursement.

All remaining balances are due upon receipt of the billing statement. We will impose a $50.00 fee for returned checks. Any accounts not paid within **[30]** days of the statement date will begin to accrue interest at 9% per annum and will be turned over for collection.

**Minor Patients**

In cases of separation, divorce and/or shared custody, any adult patient accompanying a minor child to an appointment is responsible for payment, regardless of the terms of the separation or divorce. It is the responsibility of family members, not this office, to resolve legal disputes, and terms of a divorce do not supersede the legal obligation for the accompanying parent to pay for our services.

**Missed, Late and Canceled Appointments**

This office reserves the right to assess a $**[45.00]** missed visit fee for “no-shows.” The first no show, we will give you a reminder; however, after that we will charge a no show fee.

We recognize that occasionally circumstances may not permit you to provide 24 hours’ notice, but we consider these situations to be infrequent and may consider them on a case-by-case basis.

For patients who arrive to appointments **[5]** minutes or longer after the scheduled time, we will attempt, but cannot guarantee, that the patient can be seen. In these cases, we reserve the right to charge the above-mentioned missed visit fee.

**Medical Records Copying and Transferring**

Medical records will be released within 10days of request pursuant to the Cares Act and, in accordance with the rules for the Health Insurance Portability and Accountability Act (HIPAA), Illinois law, or under other circumstances required by law.

**Medical Forms, Reports, Testimony and Miscellaneous Fees**

This office will fill out routine forms at no charge. However, we reserve the right to determine which forms are routine in nature. Our physicians may provide additional services, such as expert review and consultation, narrative reports, testimony at depositions and trials, or family conferences, at an hourly rate.

I understand and agree to all terms and conditions of this Financial Policy, including the provision that all health services rendered to me and charged to me are my personal financial responsibility.

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Signature of Patient or Responsible Party Date

(Please turn over)

**Insurance Coverage**

By receiving services from this office, you have created a legal obligation between you and this office, and you are agreeing to pay for our services. This legal obligation exists independently and regardless of insurance or health benefits you may have. Your insurance policy or health plan is an agreement between you and your insurer, not between your insurer and this clinic, even if this office is a participating provider in your insurance network, and even if we agree to bill your plan. You agree that you intend, to the full extent allowed by law, for the legal obligation between you and this office to take priority over any agreement between you and your insurer or health plan, or any agreement between your insurer or health plan and this office. In the event discrepancies exist in the agreements between and among you, this office and your health insurer or health plan, you intend for this Financial Policy to control. Therefore, you acknowledge your obligation to pay this office for any and all services rendered, regardless of whether insurance coverage is denied at any time and **for any reason**, including but not limited to the insurer’s or plan’s determination that a procedure is not medically necessary or is experimental and/or investigational.

Insurance coverage for the services we provide varies from insurer to insurer and plan to plan.

Our clinic will contact your insurer or health plan to inquire about your benefits. However, most insurers and health plans provide that an initial “verification” of coverage is not a guarantee of payment. We are not responsible for your insurer’s or health plan’s final benefit determinations, and you are responsible to pay for any care that is determined to be non-covered, even after an initial verification of coverage.

**We cannot bill insurance unless you give us permission to accept assignment on your behalf. Please sign the following if you will allow an assignment of benefits to be paid to us directly.**

□ I allow my provider to accept assignment on my behalf for payment of my bill from my insurance company.

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Patients and/or this clinic may obtain information indicating that a contemplated service or services will not be covered by insurance or the health plan. Additionally, some plans require pre-authorization as a condition of payment for certain services, after which the plan may deny or limit authorization of the services requested. In any case in which a patient and/or this clinic know that contemplated services will not be covered by a patient’s insurance, this office will ask the patient prior to service to sign a form acknowledging that the services will not be covered and that the patient will be personally responsible for payment.

Most insurance policies and health plans require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, first you must pay $100 out-of-pocket at the beginning of the year, and then you are responsible for 20% of all charges incurred during the remainder of the year. Our clinic requires the payment of these fees upon your arrival on the date of your visit. This office does NOT routinely waive co-insurance, co-payments or deductibles. However, this office permits patients to apply for discounts or waivers of fees to be granted to qualified individuals in limited circumstances under our Financial Hardship Policy. If you are interested in more information, including the factors we consider to make hardship determinations, please request a copy of our Financial Hardship Policy and application.

If your insurance or health plan requires you to obtain a written referral from your primary care provider as a condition to your receiving services from our clinic, it is your responsibility to obtain and present the referral prior to or at the time of your visit to our clinic. If your plan requires our office to complete a referral for services outside of our office, we require 3 business days to complete the forms, except in emergencies. Please plan your visits accordingly.

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