Chiropractic CareCentre
1921 N 13th St , Bismarck, ND 58501
701-222-2252
www.chirocc.com

Financial Policy

_____**CASH** - I am aware that I am totally responsible for all health care bills incurred on my account. I will pay them each visit with cash, check or credit card and in so doing may qualify for the time of service (TOS) discount/fee schedule.

_____**MEDICARE** - I understand that this office/doctors are participating providers for Medicare Part B. Clinic will bill and receive payment from Medicare for covered services as long as a medically necessary spinal problem/episode exists and is demonstrated by examination. ONLY spinal adjustments are a covered service. Extremities (wrists, elbows, knees, ankles, or feet) are NOT covered by medicare. An initial exam is mandatory prior to receiving care. Non-covered services include examination/evaluation, acupuncture, extremities, therapeutic modalities, rehab/exercise instructions, nutritional supplements and unapproved services not covered by my insurance carrier.

_____**GENERAL INSURANCE** - I understand that my insurance policy is a contract between myself and my company. This office, as a courtesy to me, will submit claims in a timely manner, respond to any written request from my insurance company, and allow up to 30 days for them to pay their portion of my bill. If this payment is not received within 30 days of service, I understand it is my responsibility to contact my insurance company to see why payment has not been issued. I am totally responsible for the balance at that time. It is also my responsibility to request pre-authorization from my insurance company for treatment (if needed), according to my policy.

_____**WORKER'S COMPENSATION** - I am aware that this office will bill my workers compensation insurance for my work related injury. I will file initial claim, respond to, and submit any correspondence received from my insurance company to this office. If my company denies liability for any reason, I understand that I am personally responsible for all health care bills accrued at this office.

_____**PERSONAL INJURY** - I understand that this office will bill my personal injury insurance company for treatment related to my injury. I am also aware that if this insurance company terminates or denies my health care bills that I, personally, am responsible for those bills. At that time, this office will submit claims to my general health ins. company if I have such coverage.

_____**MEDICAID** - I understand that this office will bill the medical assistance program for covered services which include examination and 12 spinal adjustments of the spine/calendar year. This program does not cover any other areas, but the spine. I am aware that non-covered services such as physiotherapy, vitamins, acupuncture, massage, supplies and supports are my responsibility at the time of service. I am aware that if this program does not cover my services for any reason that I, myself am responsible.

I UNDERSTAND THAT THERE IS A TIME FRAME TO FILE ALL INSURANCE CLAIMS. IT IS MY RESPONSIBILITY TO CONTACT THIS OFFICE WITH ANY NEW OR CHANGING INFORMATION ON MY INSURANCE POLICY. IF I DO NOT CONTACT OR GIVE THE CORRECT INFORMATION TO THIS OFFICE, IT IS MY RESPONSIBILITY FOR THE BILL IN FULL.

I UNDERSTAND THAT ANY SUPPLIES, SUPPORTS, OR NUTRITIONAL SUPPLEMENTS MUST BE PAID FOR AT THE TIME OF PURCHASE REGARDLESS OF THE INSURANCE INDICATED ABOVE.

PAST DUE BALANCES REQUIRE PAYMENT IN FULL OR SATISFACTORY PAYMENT PLAN SET PRIOR TO ADDITIONAL APPOINTMENTS BEING SCHEDULED.

I HAVE READ THE ABOVE AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT ACCORDING TO THE ABOVE INDICATED POLICY THAT I HAVE INITIALED.

_____ _____ _____
PRINT NAME PATIENT SIGNATURE DATE