Dr. Brandon Steinbar
Dr. Cassie Dougherty

Ballenger Creek Chiropractic

604 Solarex Ct., Suite 101
Frederick, MD 21703
301-620-1008

PATIENT RESPONSIBILITY POLICY

Your signature below forms a binding agreement between Ballenger Creek Chiropractic (BCC-provider of medical services) and the patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

MEDICAL INSURANCE

We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

- The patient is responsible for providing BCC with the most correct, active and updated information about their insurance prior to each visit
- BCC will bill to the insurance most recently provided by the patient with the assumption it is current. If the information given by the patient is inaccurate and denied, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies, we do run into timely filing deadlines so providing correct information at the time of service is critical so we can accurately bill the patient's insurance. Timely filing means the patient's insurance plan may not pay the claim after a certain amount of time after the service.
- The patient's health insurance policy is a contract between the patient and their Health Insurance Company or employer. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our physicians participate. Additionally, he patient is responsible for knowing what their plan does or does not cover. If the patient has questions about their plan and what services are covered, they should contact their insurance (typically support phone numbers are on the back of your insurance card).
- **Patients are responsible for the payment of co-pays at the time of service.**
- **Patients are also responsible for paying any applicable co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.**
- **All charges for services rendered are due and payable at the time of service.**
- In the event the patient's health plan determines a service to be "not payable", the patient will be responsible for the complete charge and agree to pay the costs of all services provided.
- BCC is not responsible for knowing what each individual patient's insurance plan does or does not cover, and patients have the right to check with their insurance about coverage before any treatment occurs at BCC.

- It is important for patients to be informed consumers, who understand the specifications of their insurance policy (i.e.vaccine and doctor visit coverage, referral/authorization requirements for specialty care, radiology, laboratory tests, etc.)
- The patient is responsible for knowing if our doctor is in-network with their insurance plan and if the services are covered under the patient's plan
- If the patient is uninsured, the patient agrees to pay for the medical services rendered to them at the time of service.

ADDRESS/DEMOGRAPHIC CHANGES

- It is important that we have the patient's correct address/phone information on file.
- The patient is responsible for alerting BCC to any address, phone or other demographic changes.

BILLING

- If the patient owes additional money after their visit, they can expect to receive a statement.
- To help keep healthcare costs down, the patient should attempt to pay their bill upon first receipt. Just as we make every effort to accommodate patients when they are in need of medical care, we expect that patients will make every effort to pay their bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office.

FINANCIAL AGREEMENT

The patient agrees that in return for the services provided to them by BCC, they will pay their account at the time service is rendered or upon insurance claim processing. If payment plan consideration is necessary, the patient understands that it is their responsibility to call and make financial arrangements satisfactory to BCC for payment (which may require applying for a financial hardship waiver). If co-payments, co-insurances and/or deductibles are assigned by the patient's insurance company or health plan, they agree to pay them to BCC.

MEDICARE PATIENTS

Medicare patients request payment of authorized Medicare benefits to them or on their behalf for any services furnished them by BCC. Medicare patients authorize any holder of medical or other information about them to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Medicare may not cover some of the services that the patient's doctor recommends. The patient will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help the patient decide whether they want to receive services, knowing they are responsible for payment. Patients must read the ABN carefully.

MINORS

Patients who are under the age of 18 need parent/guardian consent for their appointment. By signing this agreement, the parent/guardian acknowledges all of the information on this form on behalf of the patient. It is strongly recommended that the parent/guardian accompany the minor to their appointment. BCC reserves the right to identify any adult accompanying a minor to their appointment.

WORKER'S COMPENSATION AND AUTOMOBILE CLAIMS

The patient must provide at the time of service: A claim number, name & address of the carrier, date of injury, employer at the time of injury and name/number of the claim adjuster. Without this information, the patient will be held responsible for all charges and payment will be collected at the time of service. Worker's compensation patients will be required to fill out a separate form with the information necessary to bill the claim. The patient must make Parkview Medical Clinic and/or Optimal Sports Physical Therapy aware of which visit(s) should be billed to workers compensation or automobile insurance, and which should be billed to their insurance plan.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

RETURNED CHECK POLICY

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, BCC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 check service charge.

NON-PAYMENT ON ACCOUNT

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that BCC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance. Patients who ignore collection notices/letters and fail to pay their balance risk negative credit ratings and possible dismissal from the practice. Additionally, past due accounts may hinder your ability to have appointments scheduled.

I have read the above Patient Responsibility Policy and agree to abide by its guidelines.

Patient Name (Please Print) _____

Patient Signature _____ Date _____

Responsible Party Name (Please Print) _____

Responsible Party Signature _____ Date _____