PATIENT AGREEMENT AND PRIVACY NOTICE

The Florence Chiropractic and Wellness Center is committed to providing the highest level of quality chiropractic care and personal service to our patients. To achieve these goals, we need your assistance and your understanding of our office policies.

INSURANCE: If the Florence Chiropractic and Wellness Center is a participating provider with your insurance company and your insurance verifies coverage, we will bill our services as a courtesy for the patient. However, all deductibles, co-payments, and co-insurance, must be paid at the time of each visit.

It is the patient's responsibility to provide our office with current and accurate insurance information. We will require a copy of your insurance card on your first visit and will copy it for our records. We will ask for a copy annually. If your insurance changes at any time, it is your responsibility to inform our office.

Our office will obtain an insurance verification on line, informing us of your coverage. This computer information is not always accurate or detailed. Certain services provided by our office may not be covered under the terms of your individual health plan. It is YOUR RESPONSIBILITY TO KNOW AND UNDERSTAND YOUR INSURANCE POLICY COVERAGE AND BENEFITS. The patient will ultimately be responsible for any unpaid balance on treatments received in our office.

For our office to file a claim on your behalf, you must allow the release of information to your insurance carrier. Please fill out the following permission.

I, _____ give my authorization to The Florence Chiropractic and Wellness Center to release information regarding my health care and treatment in my health plan and its agents for purposes of managing my health benefit payments to my practitioner. I hereby assign this office any payments my health plan makes for services rendered to me and my eligible family members by reason of its contractual relations with my health plan and its agents.

SUPPLEMENTS/MERCHANDISE: Payments for supplements and merchandise purchased in our office are due at the time of service. We do not bill your insurance for these items. Due to health regulations, these items ARE NOT RETURNABLE.

OUTSTANDING/UNPAID BALANCES: If no payment is made on an outstanding balance after three monthly billing statements, the outstanding balance will go to collections.

RETURNED CHECKS: The charge for a returned check from your bank is $30 and will be applied to your account.

CASH PLANS: Some patients do not have insurance coverage. Even with insurance, so many patients have high deductibles and expensive co-payments that they choose to not use their insurance. We offer discounts to our regular fees called TIME OF SERVICE. These discounted fees are allowed because there are no administrative fees associated with the billing. These fees, therefore must be paid on the date of service. Please ask for a copy of the fee schedules.

MEDICARE: As a Medicare provider, Medicare will be billed for all services performed in our office. Non-covered services will be the patient's responsibility. If Medicare is your only health insurance, you will be expected to pay the amount not covered by Medicare at the time of your visit. If you have supplemental insurance to Medicare, then Medicare should forward the claim to your secondary insurance carrier. Any unpaid deductible, the $130 initial exam fee or the routine re-evaluations, any x-rays performed in our office and any adjunctive modalities are NOT COVERED by Medicare or your supplemental Insurance carries and is due at the time of service.

AUTO INSURANCE OR WORKER'S COMPENSATION: We will contact the insurance company to verify your claim. If the claim is open, we will file your claim to the respective insurance company. However, if the claim is denied or maximum benefits have been met, you, the patient are ultimately responsible to pay the unpaid amount. The verification is not a guarantee that all services will be covered.

CANCELLATIONS/NO SHOWS: The Florence Chiropractic Center does not require any minimum time to cancel an appointment. However, if a patient does not show up for a scheduled appointment, there will be a $48 fee charged to your account. This amount must be paid prior to scheduling any future appointments.

CREDT BALANCES: Occasionally, your insurance may pay for services not anticipated. Sometimes a deductible is met between your insurance verification and the time the bill is received by your insurance company. This could result in a credit to your account. We will make every attempt to promptly reimburse the patient of any credit. This is done only when you and your insurance has paid for all outstanding services. Please allow two weeks for our office to reconcile your account before issuing your check.

PRIVACY NOTICE: This is to acknowledge that I have been given the opportunity to review The Florence Chiropractic and Wellness Center's NOTICE OF PRIVACY PRACTICES. I understand that I have the right to request a copy of this office's Privacy Practice Notice located at the front desk.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date