OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided that we have prior certification from your insurance company.

2. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

3. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

4. If you are referred to another specialist or discontinue care for any reason other than discharge by the doctor, the bill is due and payment in full is expected immediately regardless of any claims submitted.

5. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient's Signature Date

OFFICE FINANCIAL POLICY

Primary Insurance:_____ Effective Date:_____

Address:_____ City/State/Zip:_____

Policy#:_____ Group#:_____ Phone#:_____

Insured:_____ Relationship to Insured_____

Medicare Patients
I request that payment of authorized Medicare benefits be made to me or on my behalf to Camp County Clinic of Chiropractic for any services furnished to me by Garth Johnson DC. I authorize that any holder of medical records about me to release, to the Health Care Financing Administration and Its agents, any information necessary to determine benefits and process the insurance claim. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Non-Medicare Patients
I authorize the release of all medical records needed to process this claim and that which is pertinent to my medical care. I assign all medical benefits, including major medical benefits to which I am entitled, to Camp County Clinic of Chiropractic & Rehab. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

I agree to the above terms and authorize Camp County Clinic of Chiropractic & Rehab to bill the charge indicated. I understand that should payment not be received within 60 days after submission of my claim, or should I terminate care before being dismissed by the provider, or if my care is terminated by the provider; I will be charged the amount due.

I authorize Camp County Clinic of Chiropractic & Rehab to retain my credit card number on file. All information will be kept strictly confidential and used only in accordance with the terms above.

Credit Card: VISA M/C DISCOVER

Name as it appears on card:_____

Card # : _____ _____ _____ Exp: _____/_____

Signature:_____ Date:_____

I assume financial responsibility for all charges.
I have read the above information and understand it.

Patient Signature:_____

If Patient is a Minor;
Parent or Guardian's Signature:_____

Relationship to Minor:_____