BROWER CHIROPRACTIC INSURANCE FINANCIAL POLICY AGREEMENT

PARTICIPATING INSURANCE COMPANY: By signing below, I understand that I am responsible for the entire balance of my bill. Brower Chiropractic will extend credit for the portion that is expected to be covered by your insurance. Therefore I agree to the following office policy requirements:

1. To pay in full (the contracted amount) until my yearly deductible is satisfied (if applicable).
2. To pay my co pay percentage of billed service(s) each visit (if applicable).
3. To pay my flat co pay per visit according to the co pay provision of my policy (if applicable).
4. To pay the balance due on each claim after the receipt of any insurance payment upon notification from this office. For plans in which we participate, this could include non-covered items or services or if indicated patient responsibility portions not collected at the time of service. Any over payment by patient and insurance will be applied to your next date of service unless you request a refund.
5. Dr. Brower makes every effort to ensure quality care is given, which may include after hours/weekend calls. If he advises or you request to meet at the office during this time, there will be an additional (to the adjustment and/or treatment) charge of $50.00. This is not typically covered by most insurance plans and will be YOUR responsibility.
6. If Dr. Brower is out of town or not available to be on call, we will have made arrangements with another chiropractic office. If they see you on an urgent basis, they may treat you as a new patient and will be billing your insurance (if they are participating with your insurance, it is your responsibility to check if they are on your plan) or billing yourself as such.
7. We require a 2-hour notice for appointment cancellations and the missed appointment fee is $35. We have a time and date stamp on our answering machine service so feel free to leave a message at any time.
8. If you have an HMO or Medicaid policy that requires a referral from your primary care doctor, it is YOUR responsibility to obtain proper referral/authorization **prior** to your visit. We will be happy to assist you if needed, but we are not responsible for missing referral denials. Many primary care doctors require you see them before they will issue a referral authorization and will not retroactively supply one.
9. If for any reason you have a patient balance due, you will receive a patient statement. If you have a zero patient balance, you will not receive a statement. There will be a 1.5% monthly finance charge that will accrue on any patient balance over 30 days past due.
10. PLEASE NOTE **(NEW ADDITION TO FORMER POLICY)**: AN OFFICE VISIT CHARGE WILL APPLY IF THERE IS A NEW INCIDENT OR INJURY OR IF YOU HAVE NOT BEEN IN THE OFFICE FOR 6 MONTHS OR LONGER. MEDICARE/INSURANCE RULES REQUIRE THAT WE CONSIDER A PERSON AS A NEW PATIENT IF YOU HAVE NOT BEEN SEEN FOR 3 YEARS OR MORE. We may or will require updated paper work and insurance cards at our discretion so that our charts conform to your insurance or State Department of Insurance requirements for auditing purposes.

ASSIGNMENT, AUTHORIZATION AND POLICY STATEMENT

I hereby assign the benefits that I am eligible to receive for the care rendered in this office, to the office. In consideration of this assignment the office extends credit. I authorize the office to release any information, per HIPPA guidelines, to any insurance company, adjuster, or attorney that will assist in the payment of claim(s). I fully understand and agree that my insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance, per what is allowed with our contract. A photocopy of this form shall be considered as valid as the original. This policy form has no expiration date unless received revocation in writing.

By signing below, I acknowledge that I have fully read, understand and agree to this policy.

Patient PRINTED Name: _____

Patient SIGNATURE: _____

Name of current insurance: _____

Date of signature: _____/_____/_____