Insurance Information

OTHER PARTY INSURANCE INFORMATION:

Insurance Company Name: ______________________________

Address: ______________________________

City: ______________State/Zip:______________

Date of accident: ______________Claim #: ______________

Adjuster's name/phone/fax number:______________________________

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PERSONAL AUTO INSURANCE/MEDPAY: ( ) YES ( ) NO

Insurance Company Name: ______________________________

Phone#: ______________________________

Address: ______________City: ______________State/Zip:______________

Claim # ______________ Policy Number # ______________

Adjuster's name/phone/fax number:______________________________

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HEALTH INSURANCE TO BE BILLED: ( ) YES (PLEASE PROVIDE CARD COPY) ( ) NO/DECLINE

Patient's personal insurance: ______________________________

Insured's name (if other than patient) ______________________________

Member ID # ______________ Group # ______________

(NOTE**: COPAYS ARE REQUIRED TO BE PAID AT TIME OF SERVICE.** BECAUSE OF SOME INSURANCE SPECIAL BILLING REQUIREMENTS (PRIOR AUTHORIZATIONS, FILING LIMITS ETC.) WE MAY NOT BE ABLE TO BILL RETROACTIVE CLAIMS. SOME CHIROPRACTIC CLAIMS HAVE TO GO THROUGH A THIRD PARTY LIKE OPTUM HEALTH AND HEALTH NETWORK SOLUTIONS)

DO YOU HAVE AN ATTORNEY HANDLING THIS CASE? ( ) YES ( ) NO

If yes, who? (name/address /phone)______________________________

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Election Not to File Health Insurance Claims (Personal Injury/Accident)

The chiropractor(s) at Falls Chiropractic and Injury are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as your auto insurance Medpay benefits or the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1. The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payors to the extent necessary to satisfy your bill.

2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.

3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.

4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.

5. None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.

2. You will be responsible for paying to the clinic the cost of any *non-covered* services you elect to receive, and your payment will be due at the time services are rendered.

3. If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.

4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.
2. I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payors who are potential sources of payment.

3. I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.
4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payors; subject only to any contractual obligation the clinic may have to my health benefit plan.

________________________________ **Printed** Name of Patient

________________________________ **Printed** Clinic Representative

________________________________ Signature of Patient (or parent/legal guardian)

________________________________ Signature of Clinic Representative

________________________________ Date

________________________________ Date

A complete copy of this executed agreement must be maintained in the patient's health care record, and a copy must be provided to the patient.

Falls Chiropractic and InjuryAuto/Personal Injury Office Policy
Richard A Laviano D. C

Fall Chiropractic and Injury will accept you as an auto/personal injury/worker's comp patient based on our clinical examination and our belief that chiropractic care will be an effective treatment of your injuries.

Your responsibility to this office will be to follow the doctor recommendations for care and to provide the appropriate financial information so that payment for services can be billed on your behalf and payment received in a timely manner.

The account balance is always the responsibility of you, the patient. Falls Chiropractic and Injury does extend credit during treatment and up to 90 days after being released from care for the injury. You may still opt to continue care with us if you choose. After 90 days, if the account is not paid via the billing parties you have provided, you will be expected to pay the account in full or make acceptable monthly payment arrangements. After 30 days of release from care if not paid in full your account will be assessed a 1.5% monthly finance charge. If the insurance or attorney does not pay this charge it will be your out of pocket responsibility. **We WILL NOT reduce or negotiate rates of our charges at any time**. Our charges are reasonable and customary.

We can bill the liable party insurance, your Medpay with your auto policy and/or health insurance. You will be given a sheet to provide this information. Any overpayments will be refunded to you unless you notify us to return to the issuing party. You are responsible for determining if you need to have them reimbursed or may keep the overpayments.

Following the completion of your treatment, we will notify the liable party/parties and forward all bills and medical records directly to them. In some cases, you will be asked to return for a permanent disability/injury exam in 4-6 weeks and records/bills will be held until that is completed. Please advise us in advance if you would like a copy of your medical records for your personal use as it is easiest to make multiple copies at one time.

Our cancellation/reschedule of appointment policy is a 4-hour notice. The fee for short notice or missed appointments is $50 and may not be covered by the liable party or health insurance. We do have a date and time stamped message system to allow for timely cancellations.

______________________________	________ / ________ / __________
Patient Signature	Date
______________________________	______________________________
Patient Printed Name	Witness Signature

FALLS CHIROPRACTIC AND INJURY:

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Falls Chiropractic and Injury to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Falls Chiropractic and Injury any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on ___________________________ (date of the accident) to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Falls Chiropractic and Injury , from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to Falls Chiropractic and Injury for its services rendered.

I appoint Falls Chiropractic and Injury as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Falls Chiropractic and Injury.

I authorize Falls Chiropractic and Injury to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Falls Chiropractic and Injury for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Falls Chiropractic and Injury is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Falls Chiropractic and Injury for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

Patient Signature ____

Date ____

Witness ____

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Falls Chiropractic and Injury hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Falls Chiropractic and Injury hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Falls Chiropractic and Injury agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

By: ____Date:________________________