

**REISTERSTOWN FAMILY CHIROPRACTIC
FINANCIAL POLICY**

MAJOR MEDICAL GROUP / INDIVIDUAL HEALTH INSURANCE

Most insurance companies have benefits for Chiropractic treatment. The yearly deductible and co-payment will vary among insurance companies. It should be pointed out that our contract for services is with you, the patient. We work for you; not for your insurance company. Reisterstown Family Chiropractic provides the best services that we are capable of providing and expect that payment for those services will be made as promptly as possible. It is important, therefore, for you to become an informed consumer relative to your insurance coverage.

OFFICE POLICY

****1.** As a courtesy to you, we will call to see if your health insurance policy includes Chiropractic benefits. We will notify you of the percentage that your policy covers and any limitations to the payments. If we are informed that you have not met your yearly deductible, this balance is required to be paid by you directly to our office. We will need a copy of your drivers' license and your insurance card to be kept on file in your numbered chart. In addition to our office verifying your insurance benefits, we require that you, the patient, call your insurance company to verify your own coverage. We will provide an Insurance Verification form, to be completed by you within your first 3(three) visits.

****2.** We will bill your health insurance carrier and have you assign payment to us for treatment in our office if you have provided us with the necessary information. Your co-payment is to be paid by you at the time of each visit.

****3.** If you receive a check from the insurance carrier for services rendered in our office, bring the check and any attached forms to this office immediately. We will need to have the documentation for what dates of services and what services were paid by the insurance carrier. You will not be permitted to make "payments" on an insurance check mailed to you. The account may be turned over to a collection agency if full payment is not made immediately.

****4.** The verification provided by this office is not a guarantee that your insurance carrier will pay what has been stated. Your account is ultimately your responsibility. Any discrepancy between what is quoted on the insurance verification form and what is actually paid by your insurance carrier is your financial responsibility. You are more than welcome to dispute an adverse decision with your insurance company directly, but you will be responsible for making a payment in full to our office immediately.

****5.** We will accept payment on your account in the form of CASH, ATM CARD, VISA, MASTERCARD, DISCOVER or CHECK.

****6.** If any insurance or personal information changes during the course of treatment, you are required to inform this office immediately. (Such as your insurance policy/plan updates or terminates, you have moved, or changed your phone number, etc.)

****7.** There are a certain number of appointments available each day and often patients who are injured are unable to be scheduled the same day that they call. With this in mind, if you are unable to keep a scheduled appointment, we ask that you give us the courtesy of a phone call, so that we may schedule another patient in that time slot. Thank you for your cooperation.

****8.** If you receive a bill, the payment is due upon receipt. All accounts with a balance over 45 days will be assessed a 1% late charge per month on the unpaid monthly balance. Payment plans can be arranged through the Billing department (410-517-2400). In the event that an account becomes assigned to a collection agency, the patient will pay 100% of collection agency fees, 100% of court costs, and 100% of attorney's fees.

****** I HAVE READ, UNDERSTAND, AND ACCEPT THESE POLICIES IN FULL. ******

PATIENT SIGNATURE _____ DATE _____