Financial Policy / HIPPA / Release of Records

Health Insurance: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, deductibles, co-insurance and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my insurance is a contract between me and my insurance company and that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. Our most common codes (charges) are:
99203 (Exam - $85) 98943/98940/98941 (Manipulation - $25/$45/$45) 97012 (traction - $20) 97110 (therapeutic exercises - $20)

If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred. I also understand that I AM *RESPONSIBLE FOR GETTING ANY REFERRAL NEEDED FOR TREATMENT IN THIS OFFICE . IF A REFERRAL IS NEEDED AND IS NOT RECEIVED IN THIS OFFICE, THEN I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES*.

Workman's Compensation- you need to notify the receptionist NOW! Ohio State law is specific on how we must bill your charges and what specific paperwork needs to be filled out.

Automobile Accidents- you need to notify the receptionist NOW if you are here for treatment related to an automobile accident. We require on file your car insurance, the person's at fault car insurance, your driver's license, your health insurance, and a copy of the accident report. I also give any insurance carrier and/or attorney authorization to directly pay Polaris Family & Sport Chiropractic for the treatment rendered at our office. I authorize & direct payment to Polaris Family & Sport Chiropractic of any sum I owe now or hereafter owe to him by my attorney &/or by any insurance obligated to reimburse.

ACKNOWLEDGMENT & UNDERSTANDING:

I understand that if it is determined: **a)** That there is no insurance coverage, **b)** If your insurance company refuses to acknowledge & assign payment directly to the doctor, **c)** If your insurance company notifies us that you are responsible for additional payment to our office, **d)** If I stop care for any reason, or **e)** If a liability claim exists, & my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney... THEN PAYMENT FOR SERVICES RENDERED BY THE DOCTOR AT POLARIS FAMILY & SPORT CHIROPRACTIC WILL BE MADE ON A CURRENT BASIS & MY PORTION OF THE CHARGES WILL BE PAID IN FULL AND DUE IMMEDIATELY. I further understand should collection of my account be referred to an attorney for payment or collection agency, I am personally responsible for all collection fees, interest, & attorney fees that may occur.

I acknowledge I have read all eight pages of the "Notice of Privacy Practice," and I understand and agree to its terms (Please ask the office assistant if you want a copy of the Privacy Policy). Furthermore, I authorize Polaris Family & Sport Chiropractic, Inc. to release any information deemed necessary concerning my condition to any doctor, insurance company, attorney, collections, adjustor, or other business necessary regarding my case in this office.

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Patient Name (Please Print) **Signature (Patient or Guardian)** **Date**