Coast Chiropractic Centers Payment Policy

PATIENT'S NAME _____DATE_____
GUARANTOR (if different than patient) _____
GUARANTOR (if different than patient) D.O.B ____/_____/_____ SS# _____-_____-_____

Thank you, for choosing our office to meet your health care needs. In choosing to use your group health insurance to meet your financial obligation with our office, you must clearly understand and agree to the guidelines listed below. If you have any questions regarding our policy, please do not hesitate to speak with our accounts receivable administrator.

1. You will be considered a cash patient until our office qualifies and accepts your insurance coverage. We will verify your chiropractic benefits within 72 working hours of your first visit. These benefits will be reviewed with you so that you have a clear understanding of what your financial obligation will be at each visit.
2. Many of our patients are covered by health insurance. Due to extreme variations in insurance policy coverage, we encourage our patients to check with their insurance company or employer to determine their specific coverage. This includes the participating provider list and out of network payment schedule.
3. You must pay **all deductibles and co-pays in full at the time of visit** unless prior authorization was given and a payment policy was agreed upon.
4. If your plan requires a referral from your primary care doctor or precertification prior to your visit and you fail to obtain, you will be responsible for full payment of that visit at time of services are rendered.
5. If we do not participate with your insurance plan, you are responsible for full payment of your visit, even if it exceeds the insurance's determination of "usual and customary allowance" for the procedure performed.
6. If your insurance policy requires a treatment plan be submitted for continued care, Coast Chiropractic Centers will do this on your behalf. As a result of their review they may impose restrictions on the number of visits the time allotted for your care with our office, you will be responsible or any visits that exceed the imposed restriction. If an appeal process is appropriate we will help you with appealing the decision to the appropriate parties.
7. If you are restricted to a number of visits or maximum dollar limitation allowed per year imposed by your insurance plan, you will be responsible for payment of any visits over that allowance.
8. We can not accept responsibility for collecting an insurance claim after 60 days or negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier. You are ultimately responsible for payment on your account. If you have a dispute with how your insurance company processed a claim, you are responsible to contact them directly to resolve the dispute.
9. If your insurance is terminated or there is any change in your plan, it is your responsibility to notify us immediately.
10. Infrequently insurers or patients submit payments in excess of the required amount. When we receive mistaken payments or large overpayments, we attempt to make a good faith effort to refund the reimbursement or apply the overpayment to future billings. Certain credit balances will not be refunded due to administrative burden. Credit balances equal to the value of an adjustment ($48) will neither be automatically refunded to the patient or any third party payor if after any reasonable attempt, administrative burdens makes it to difficult to continue to process the refund. Patient disclaims and right, title or interest to the knowingly and voluntarily waives and legal demand to the foregoing credit balance, which shall not constitute unclaimed or abandoned property in the possession of a holder as defined in the Unclaimed Property Act, 72 P.S. §1301.1 and §1301.10(1).
11. I herby agree that in consideration of the services rendered I understand that any portion that is not covered by my insurance will be responsibility. This consent and agreement will remain in effect as long as the patient remains active in our practice.
12. There is a $25 cancellation fee for any missed regular appointments with less than 48 hour notice. There is a $50 cancellation fee for any missed SONOMA retests.

PATIENT/ GUARANTOR SIGNATURE _____

WITNESS SIGNATURE _____