Financial Policy & Assignment of Benefits

The following form represents our financial policy. You are required to read and sign this agreement prior to receiving any treatment and/or services. You will not be admitted for care without it.

Financial Policy:
PLEASE READ CAREFULLY (before signing)

Some (and/or perhaps all) of the services provided in our office may (or can) be considered, by your insurance provider, as non-covered (or non-essential) services and may not be considered "reasonable and/or necessary". Your insurance policy is a contract between you and your insurance company. We bill them for services provided. They remit or deny payment based on the provisions in that contract. There is never any guaranty of payment provided by your insurance carrier. **It is your responsibility to pay for any deductible amount, co-insurance, co-pay, or any other balance not paid or covered by your insurance. You are financially responsible for all charges for services rendered regardless of any applicable insurance or benefit payments. We will bill you for these charges and if not paid will be sent to a collections recovery agency or law firm.**

Insurance does NOT cover maintenance care and/or nutritional supplements. Maintenance care is considered medically unnecessary by all insurance companies. Federal plans (Medicare and Medicaid) explicitly exclude maintenance-type care from coverage. Therefore, you are responsible for all charges incurred for maintenance care.

Participating Insurance Plans:

Please note that most insurance plans have a deductible. YOU MUST PAY THE FULL DEDUCTIBLE BEFORE THE INSURANCE WILL PAY THE COST OF YOUR CARE. This is not negotiable.

For those plans with which we are participating providers, it is our policy to collect all co-pays, co-insurance or any deductibles that are due at the time of service. In order to properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card and driver's license on file. In the event that your insurance coverage changes to a plan with which we do not participate, refer to the paragraph below for information regarding coverage. For minors, the adult accompanying a minor and the parent (or guardian(s) of the minor) are considered guarantors for the minor's account. For an unaccompanied minor; by law, all care will be denied unless the office or provider has been pre-authorized to treat and therefore charge for treatment with an approved credit plan or insurance plan.

Non-Participating Insurance Plans:

We do not accept assignment (payment) of insurance benefits, nor bill your insurance company if we are not a participating provider. Full payment (at the Self-Pay rate) is expected at time of service. If you want to use your insurance, and if we are not providers with that insurance carrier, we suggest you find a provider in your network. *Review the next page for the Fee Schedule for Self-Pay Patients.*

Assignment of Benefits:

Authorization to Pay Benefits to Physician/Office (Statement):

I hereby assign payment directly to the Office for any and all procedures and treatments provided, if any, otherwise payable to me for services provided at the Office, but not to exceed the indebtedness to the Office for those services. *I understand that I am financially responsible for charges not covered by my insurance.*

Authorization to Release Information (Statement):
I hereby authorize the Office to release any information acquired in the course of my examination and/or treatment(s) to my referring practitioner and/or my insurance company.

Acknowledgement of Financial Policy and Assignment of Benefits (Statement):

I have read and understand and agree to comply with the above Financial Policy and Assignment of Benefits provisions and agree to all provisions outlined therein.

X_____ _____
(Signature of Patient, Parent/Guardian or Responsible Party) **Date**

Fee Schedule for Self-Pay Patients:

This is the fee structure for Self-pay and/or Non-insured patients and/or patients with whom the doctor(s) will not accept assignment. You must confirm with your individual practitioner which insurance plans he participates with. If he is not in-network with your insurance carrier he will not accept insurance coverage from your insurance carrier. Self-pay (time-of-service) visits are billed primarily by time but also by services provided. Fees are listed as follows:

Service **(time-of-service rates only)***	**Time allotted**	**Discount fees**	**Regular fees**
First exam (only)	1-15 minutes	$95	$125-280
First exam + first treatment	1-60 minutes	$165	$180-320
Bundled (all) services (with or without chiropractic)	1-20 minutes	$70	$120
Bundled (all) services (with or without chiropractic)	21-40 minutes	$140	$185-245
Bundled (all) services (with or without chiropractic)	41-60 minutes	$210	$245-305
Chiropractic (adjustment) only	1-10 minutes	$50	$65
Student Rate first exam + first treatment	1-45 minutes	$145	$180-320
Student Rate for bundled (all) services	1-20 minutes	$50	$120
Student Rate for bundled (all) services	21-40 minutes	$100	$185-245
Student Rate for bundled (all) services	41-60 minutes	$150	$245-305

Acknowledgement of Financial Policy for Self-Pay and non-insured patients (Statement):

I have read and understand and agree to comply with the Financial Policy as stated in this document. Additionally, I hereby declare that I am unable to pay for the standard service fees at Active Chiropractic Group (i.e. Knight Chiropractic & Acupuncture, P.A., Tim Bhakta, P.A., Arbor Creek Chiropractic, P.A., etc.) and/or waive the right to use insurance for any and all services rendered as they may or may not be covered by my insurance carrier, regardless of whether the service(s) rendered and office staff and facility are listed as providers in any or all insurance networks. I agree to pay for all services as listed in the Fee Schedule for Self-pay Patients section of the Financial Policy. I understand that additional costs may/will apply for unrelated charges of the fee schedule. I acknowledge that the fee schedule can change without notice and new fees will apply with or without being provided with notice of changes.

X_____ _____
(Signature of Patient, Parent/Guardian or Responsible Party) **Date**