COMPREHENSIVE CHIROPRACTIC AND SPORTS INJURY CENTER, P.C.
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FINANCIAL POLICY

Thank you for allowing Comprehensive Chiropractic & Sports Injury Center, P.C. and Dr. Douglas Obetz to assist you with your health care needs. Our office is committed to provide the very best chiropractic care and successful treatment. The following is a statement of the financial policy, which you must read, agree to, and sign prior to treatment. This financial policy applies to any and all services rendered by the doctors and the staff provided at Comprehensive Chiropractic & Sports Injury Center, P.C.

PROOF OF IDENTIFICATION:

The patient is required to provide a picture ID. A copy of a valid state issued driver's license is preferred. If you are underage, your legal guardian must provide this information.

PRACTICE PAYMENT POLICY GUIDELINES:

1. Patients/Guardians are financially responsible for all charges, regardless of third-party involvement.
2. Full payment is due at the time of service, unless prior insurance billing arrangements have been made.
3. Patients with insurance are required to pay for all 'out-of-pocket' financial obligations at time of service.
4. We accept cash, check, and the following credit cards: Visa, MasterCard, Discover and American Express. There is a $25.00 service charge for all returned checks.
5. We will not file any secondary insurance. This will be the patient's responsibility. However, this office will assist the patient with any needed information required in the filing process.
6. There will be a **$45.00 No Show Fee**.
7. There will be a **$45.00 Cancellation Fee** for failure to contact the office within 24 hours of your appointment time.

PATIENT RESPONSIBILITIES AND FINANCIAL POLICIES:
Provide accurate information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance, and other billing information. If any information changes-name, address, phone, insurance coverage, etc…, you must inform this office immediately. *Insurance denials or billing errors due to patient supplied information or misinformation will result in the transfer to the patient account balance for the patient's immediate financial responsibility.*

Know Your Insurance Coverage, Benefits, and Referral Requirements:
Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage, benefits, and referral requirements to receive treatment, diagnostics and therapeutic services from this practice. **Patients are responsible for securing the necessary written referral, pre-authorization, or pre-certification from your primary care physician or health**

plan prior to services being rendered, if applicable. If this office does not receive the necessary authorization prior to your appointment, the appointment will be rescheduled, or you will be personally responsible for payment of services that day. Pleases present your Insurance ID card to our staff upon registration/sign-in.

Self-Pay Patients:
Patients without health insurance coverage are expected to pay for services received in full at time of service, unless a satisfactory payment agreement is made prior to service rendered. It is the policy of this office that a credit card be kept on file for payments that are more than 45 days past due.

Patients with Private Insurance:
Dr. Obetz participates with some insurance company health plans. This office will inform you if Dr. Obetz does/does not participate with your plan. This office as a courtesy, will file claims with your insurance company provided you authorize the 'assignment of benefits' below for payment directly to this practice. For participating insurance plans, this office will accept payment based upon contractual agreements. Co-payments due for each date of service as well as payments for supplements, supports etc. not covered by your insurance company are due at the time of service or when products are given. For plans in which Dr. Obetz does not participate (i.e. there is not contract agreement), the practice will expect full payment from the patient at the time of service. *Any coverage or payment dispute is a matter between the insurance policy holder and the insurance company.*

Medicare Coverage:
CCSIC will file Medicare claims on behalf of the patient. Please see the attached Medicare Advance Beneficiary Notice of Noncoverage (ABN). If you do not receive this please ask the front desk person. If after reading the ABN you have any questions please speak with Dr. Obetz or Kara.

Personal Injury (PI), Workers Compensation (WC) and Motor Vehicle Accidents (MVA) Patients:
If your injuries are the result of a PI, WC, or MVA, claims will be submitted to your car's med pay, your attorney (if applicable) or workers compensation department/company handling the claim. Claims will not be submitted to your general health insurance carrier. As stated above it is your responsibility to provide this office with the correct and complete information specific to your case. This office understands the circumstances of these types of cases that payments settlement takes time. However, if no payment has begun or payment in full has not been made within 18 months from the commencement of treatment, payment responsibility will immediately become the patient's responsibility and payment/payments will be expected to begin.

Patient Payment Agreement:

I understand that I am fully financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, coinsurance, co-payment, or services deemed as 'non-covered' by my insurance carrier at time of service. If my insurance has not paid on my account in 75 days, the outstanding services and amount will become my responsibility for immediate payment unless special arrangements are made. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service, and/or another reason, I agree to pay all charges within 45 days of services rendered. I understand that failure to pay outstanding balances or make payment arrangements within 90 days, the amount due will be considered delinquent and subject to legal action or assignment to a collection agency or attorney. I also agree to pay for reasonable collection and attorney fees and authorize the release of any personal demographic information (i.e., name, address, telephone / cell numbers, SS # 's etc.) to such persons or agencies. I further understand that failure to pay delinquent accounts may result in a finance charge assessment of 1.75% per month/ 21% APR, and the possible dismissal of the patient from this practices care. I agree to pay $25.00 returned check fee for each payment that is returned by the bank. Copies of medical records can be obtained with advanced written notice in accordance with Virginia Code, with charges not to exceed $0.50 per page (double sided copies) for the first 50 pages and $0.25 per page thereafter, plus a $10.00 handling fee and any postage expenses. Chiropractic records may not be faxed. Request for records may be faxed. The completion of special forms or reports will have a minimum charge of $25.00 for each form.

Authorization and Assignment of Benefits:

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of chiropractic records and/or other records and information, as stated herein, whether manual, electronic, or telephonic. I authorize the Practice/this office to apply for benefits for services rendered to me or minor child under any health insurance policies providing benefits from my insurance company to the Practice/this office (including benefits payable under Title XVIII of the Social Security Act). I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company for insurance information existence of insurance and coverage of my benefits. I also authorize release of any demographic information, (i.e., name, address, telephone number, SS#, date of birth, etc.), to any attorney or collection agency if above financial terms are breached.

In consideration for chiropractic services rendered I acknowledge notice of the financial policy and agree to pay for said chiropractic services according to the above terms. My signature below indicates that I have read, understand and agree to the above policy.

_____ _____

Patient/Responsible Party/Guardian Signature **Date**

_____ _____

Patient/Responsible Party/Guardian Printed Name **Date**