CLINIC POLICIES

Thank you for choosing Cecil Chiropractic as your health care provider. We are committed to the success of your treatment. The following are statements of our Policies which we require you read and sign prior to any treatment.

All patients must complete our Patient Information, Health Information, Policy and Coverage forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. WE ACCEPT CASH, CHECKS, CREDIT AND DEBIT CARDS. WE OFFER AN EXTENDED PAYMENT PLAN WHERE NECESSARY AND A FINANCIAL AGREEMENT IS SIGNED.

REGARDING INSURANCE

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Cecil Chiropractic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. Specifically, most insurance plans do not provide coverage for maintenance or palliative care. If you are unsure as to the nature of the treatment you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

REGARDING DEDUCTIBLE AND CO-INSURANCE/CO-PAYMENT OBLIGATIONS.

By law we are required to make reasonable efforts to collect deductibles and co-insurance and/or co-payment obligations. All co-insurance and/or co-payments and deductibles are required to be paid under the terms of your contract with your insurance carrier. By law we are responsible to attempt collections of these amount once they are identified to us on your explanation of benefits. It is the policy of this clinic to bill for all co-insurance, co-payment and deductible amounts. If you have difficulty meeting your full responsibility under the terms of your insurance contract, please contact a member of our billing staff so that financial arrangements for payment can be made.

USUAL AND CUSTOMARY FEES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Our fees are generally considered to fall within the acceptable range by most companies and the charge for each service is determined based on the relative value (RVU) of the service as published by the Center for Medicare/Medicaid Services (CMS) formerly known as HCFA. Not all carriers utilize CMS RVU's when determining their allowances for a service. Many carriers implement an arbitrary schedule of allowances. Notwithstanding any contractual provision to the contrary between this clinic and your health insurance carrier, this clinic will accept your carrier's allowance as your payment as full provided that you meet any co-insurance, co-payment and/or deductible obligation assigned by your carrier within 60 days of the date of the EOB. This statement does mean that we accept the carrier's payment as payment in full. Your carrier generally only pays a portion or percentage of the allowed fee for a particular service in accordance with the terms of your benefit plan. Deductible, co-insurance and/or co-payment amounts are your responsibility.

NON-COVERED SERVICES

Your treatment may involve services that are not covered under your health benefit plan. You have the right to deny receipt of these services. If you elect to receive any or all services recommended, you will be fully responsible for payment of these services. We make every attempt to verify the limitations of your health insurance benefit plan. As the information we receive is not a guarantee of coverage or benefits, we cannot be responsible for the validity of the information supplied to us by your carrier. You are responsible to verify your coverage limitations based on your benefit contract.

ADULT PATIENT

Adult patients are responsible for full payment at time of service unless we are accepting assignment for insurance. In this case, we recommend that you make some payment toward your obligation each visit. As detailed above you agree to be responsible for all co-insurance, co-payment, deductible and non-covered services as determined by your insurance carrier. For patients without insurance coverage, you agree to be responsible in full for all services provided in accordance with our negotiated fee schedule. In order to avoid fees for production of statements in the event we have to bill you for unpaid balances, we offer the option of billing your remaining balance to your credit card provided that you provide necessary information and authorization for credit card billing.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless patient responsibility has been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at time of service has been verified in advance of treatment.

Permission is hereby given by the undersigned to the Doctors of Cecil Chiropractic and whomever they designate to treat the minor patient. I certify by my signature below that I am the minor patient's legal guardian.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. Further, understand that non-compliance with your ordered treatment plan may negate our ability to represent your services as medically necessary to your insurance carrier. This is to remind you that in order for the services performed in this clinic to be billed to your insurance carrier, those services must be considered to be medically necessary. Part of satisfying the medical necessity requirement is for this clinic to develop a treatment program that is oriented toward improving your level of functionality to your maximum potential. Our ability to assist you with meeting these goals is based on your commitment to your ordered treatment program. Non-compliance with your treatment plan will interfere with our ability to make the progress that is required by your carrier to establish the medical necessity of the services such that they become covered by your insurance plan. If you are non-compliant with your ordered treatment plan you will be discharged from that plan. If this is the case, you will be offered maintenance treatment on a schedule that you can determine. This type of treatment, however, is not generally a covered benefit under most insurance plans and this clinic will not bill these services to your carrier. The burden of payment for this type of treatment will be your responsibility.

FINANCIAL ARRANGEMENTS

Where necessary based on your financial circumstances, we will permit you to make payment arrangements that will permit you to meet the obligations detailed in your insurance benefit contract and this policy. Strict adherence to the financial arrangements you make is required. You must relay any changes you may require to your previously agreed financial arrangements to our financial department immediately. Past due balances that cannot be handled in house will be referred to outside collection agencies or to litigation for collection. Where this is necessary, you agree to be additionally responsible for any costs and attorneys' fees related to the collection of unpaid amounts plus interest at the rate of ten percent (10%) per annum for each day payment is more than 30 days overdue.

Credit Card Account to Bill for Deductible, Co-Insurance, Co-Payment or Non-Covered Services:

X_____EXP_____

Credit Card Number

I have read and agree to these clinic policies and authorize this clinic to bill my credit card as detailed above or where no credit card information is evident, agree to complete a financial agreement related to service received but not paid for in full by my insurance benefit plan.

X_____Date_____

Signature of Patient or Responsible Party/Guardian

X_____Date_____

Signature of Staff Witness

RELEASE OF INFORMATION – HIPAA PRIVACY

This clinic is concerned about the privacy of your individually identifiable health information and has enacted policies and procedures to protect your privacy as required by the Health Insurance Portability and Accountability Act of 1996. A notice of this clinic's privacy practices is posted in the clinic or can be obtained from a staff member.

I acknowledge that I have received the Notice of Privacy Practices FOR PROTECTED HEALTH INFORMATION.

Date: _____ Name of Patient _____

Print Name

_____

Signature of Patient/Personal Representative