Restoration Health Chiropractic Payment Policy

RHC is NOT an insurance based service provider
SERVICE IS RENDERED AND FEE IS COLLECTED EACH VISIT

If you have health insurance:
Because of the diversity in plan policies and benefits, we recommend that you call your carrier to question your plan's policy on benefits for chiropractic care "in network" or "out of network", whichever applies. As a courtesy for your payment as service is rendered, this office will generate and mail insurance claims for you; however, payment for services will be collected as rendered until your carrier responds to our claims.

If you have Medicare:
You will be responsible for the annual Medicare deductible as well as the exam & x-ray fee which Medicare will not pay. RHC is a participating provider and WILL ACCEPT ASSIGNMENT direct from the TRADITIONAL Medicare program only. If your secondary carrier is a Medigap policy, we will submit the information directly to them. If you have a supplemental policy, we will make copies of your "Explanation of Benefits" forms for treatment in this office only for reimbursement. Your copay will be collected.

If you are enrolled in one of Medicare's HMO Plans (Health First), we cannot process a claim for you.

If you had an auto (or other) accident: We will bill the responsible insurance company only AFTER we verify your policy benefits and have guarantee of payment. If an attorney is involved, we will request a "Letter of Protection". You MUST supply an Accident Report, Insurance company name, Address and Phone #, PIP Claim #, Adjuster's name, & Attorney's name, (if handling this case**).**

If you were hurt at work: Your insurance carrier MUST AUTHORIZE care rendered by FCC. We will bill the liable insurance company directly. You will be responsible to bring in the necessary information. (Copy of Injury Report, signed Authorization to Treat form, Insurance company name, address and phone #)

I HAVE READ & AGREE TO THE ABOVE TERMS OF PAYMENT

Print Name

Signature ______________________ Date

FOR ALL INSURANCE PROCESSING BELOW MUST BE SIGNED

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount or medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage and hereby assign at clinic's request, and directly convey to Restoration Health Chiropractic all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of an applicable insurance or benefits payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize my plan administrator or fiduciary, insurer and, my attorney to release to such doctor and clinic any and all plan documents, insurance policy and /or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claims submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expense. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

______________________________ ______________________
Signature of Insured / Guardian Date

IF YOU ARE SELF-PAY PLEASE ADVISE FRONT DESK FOR ADDITIONAL PAYMENT OPTIONS