

Lenz Chiropractic, PC Office Policy

Effective: January 1, 2014

Welcome to our clinic! We are committed to providing you with the best possible care. Our fees reflect our professional commitment to excellence. If you have insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment and office policy.

FINANCIAL OBLIGATION

Payment of cash, check, debit or credit card as well as credit through Care Credit at a zero percent or low interest rate to you is accepted.

We will assess a \$25 fee for all returned checks. Payment for the returned check and amount unpaid must be paid by credit card or cash.

All deductibles, co-pays and co-insurance must be paid on the date of service. For patients that do not carry health insurance, payment in full on the date of service must be received. Please ask about our fees before treatment if you have not already been informed.

I (the patient) agree that I am financially responsible for payment of all amounts for services and products provided by Lenz Chiropractic, PC. I am responsible to pay for my services regardless of insurance coverage or other agreements between Lenz Chiropractic, PC and my insurer, or prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO) or Medicare, as well as all other insurance companies, I understand that I am financially responsible for non-covered services or deductibles, co-pays or co-insurance as defined in my policy or plan. If you have secondary insurance, you are still responsible for your primary insurance payment at the time of visit. Our office will process your secondary insurance as a courtesy once your primary insurance explanation of benefits has been received.

If there is a balance on your account, a statement will be sent on a monthly basis. A \$3.00 billing charge will be applied to your account each time a statement is sent. Payment in full is due upon the first statement received. If this is not possible, our office policy requires all balances to be paid within 90 days or in some instances, a payment schedule can be set up. On these accounts, a payment agreement must be set up and signed. If the payment agreement is broken at any time, the agreement **will be null and void and the entire balance will be due**. In the event you cannot pay off your balance within 90 days, we can offer you extended credit through Care Credit at a low interest rate. Please ask us for more details. Furthermore, I understand that Lenz Chiropractic, PC may deny services until my personal balance is paid in full.

All durable medical equipment (i.e. – orthotics, pillows, supplements, etc) is required to be paid in full when you receive them. If any payment is received from your insurance company for the supplies, it will be credited to your account for future services or you may receive a refund check in the mail by request.

I understand Lenz Chiropractic, PC may charge a reasonable and customary fee for extraordinary processing such as reports, copies of records, and paperwork for insurance companies that we do not personally bill (i.e. – Aflac, Combined Insurance, attorney reports, etc), etc.

It is understood and agreed that any amounts paid to Lenz Chiropractic, PC for x-rays are for examination only. The negatives are property of Lenz Chiropractic, PC and will remain as part of the permanent patient file. I understand Lenz Chiropractic, PC will not be held responsible for any pre-existing medically diagnosed condition.

CONSENT TO BILL INSURANCE

I understand that Lenz Chiropractic, PC will provide routine and reasonable insurance claims processing to most carriers as a **courtesy** for me. In return, they expect cooperation from me, if necessary, to help collect any amounts due. I understand Lenz Chiropractic, PC reserves the right to refuse this courtesy or withdraw it at any time.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that Lenz Chiropractic, PC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized is paid directly to Lenz Chiropractic, PC. I also understand that this amount will be credited directly to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Lenz Chiropractic, PC fees are considered customary and reasonable by most insurance companies and therefore are covered up to the maximum allowable determined by each insurance company. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area. If my insurance company has not paid a claim within sixty (60) days of submission, I agree to take an active part in the recovery of my claim. If my insurance company has not paid within ninety (90) days of submission, I accept responsibility for payment in full of any outstanding balance.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release Lenz Chiropractic, PC and its employees to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services it deems necessary in my case. I furthermore authorize Lenz Chiropractic, PC to disclose all or part of my patient records to any person or corporation which is or may be liable under contract to Lenz Chiropractic, PC or to me or a family member or employer of me for all or part of the Lenz Chiropractic, PC charges, including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or my employer.

TIMELY APPOINTMENTS

Lenz Chiropractic, PC does everything they can to provide the best possible service to all their clients. I understand that when I schedule an appointment that I am closing off that appointment to other potential patients. Therefore in order for Lenz Chiropractic, PC to provide timely service to all patients, I understand that Lenz Chiropractic, PC requires that if I cannot make it to my appointment and have to cancel for any reason that I give a minimum of a 24-hour notice. I agree that I may be subject to a \$30 no show fee for chiropractic services and a charge of ½ the fee for the massage that was scheduled at Lenz Chiropractic, PC and at sole discretion for habitual failure to provide such notice. Furthermore, I understand that third-party payers do not cover this fee.

I have read this credit and office policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a credit-reporting agency. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees as well as the entire account balance due which may include services, return check charges and billing charges. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time. I have read and understand the foregoing. I hereby authorize insurance benefit payments to be made directly to Lenz Chiropractic, PC and their employees for their services. Thank you!

Patient Name (Please print)

Patient Signature (or parent/guardian of a minor patient)

Date