New Health Chiropractic Billing Policy

- ✓ **I understand payment is due at the time services are rendered.**
- ✓ I understand that it is my responsibility to provide New Health Chiropractic with current, accurate billing information at the time of check in and to notify New Health Chiropractic of any changes in the information.
- ✓ I understand qualified insurance charges can be submitted to primary insurance carriers by New Health Chiropractic. I understand this is done as a **courtesy** and New Health Chiropractic will not enter into a dispute with any insurance carrier over any claim. This is ultimately my responsibility and obligation.
- ✓ I understand that New Health Chiropractic does not guarantee that my insurance will cover treatment.
- ✓ I understand that if my account becomes past due, it may be turned over to a collection agency. If my account is not paid in full and is turned over to a collection agency and/or attorney, then I agree to be responsible for all reasonable fees necessary for collection of the delinquent account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of balance.
- ✓ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash or credit card.
- ✓ **I understand that I must give 24 hour notice for canceling an appointment. If 24 hour notice is not given I understand that I may be charged a $35 fee which is my responsibility, not the responsibility of my insurance company.**

My signature below confirms that I have read these billing policies and understand my financial obligation.

_____

Print Name

_____ _____

Signature **Date**

_____

Relationship to Patient

BLUE CROSS / BLUE SHIELD PATIENTS ONLY:

Our office does not guarantee that your insurance carrier will pay.

I hereby authorize payment directly to New Health Chiropractic for services rendered to me. I understand that services rendered to me by New Health Chiropractic will be billed to my insurance company as a courtesy to me, but that I am personally responsible and liable for any and all medical fees billed. I understand that according to the requirements of my insurance plan, that it is my responsibility to pay for any and all **deductibles, co-pay and coinsurance expenses as well as any service deemed not covered** by my insurance at the time of service. All denied fees must be paid in full upon receipt of notification. I am aware that I will be billed for amounts my insurance determines are patient responsibility on the Explanation of Benefits and will be due upon receipt of notification. Accounts will be considered late after 30 days and subject to collection and collection fees and/or interest charges. I hereby authorize New Health Chiropractic to release to any insurance company, or their representative, any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care necessary to process my insurance claims. Our office will not enter into a dispute with your insurance company over any claim. *This is ultimately your responsibility and obligation.*

SIGNATURE_____ **DATE** _____

TURN OVER

MEDICARE PATIENTS ONLY:

I understand that Medicare will only consider services that it determines to be "reasonable and necessary". I understand that New Health Chiropractic is a non-participating provider for Medicare and I will be asked to pay upfront for services at the time they are rendered. I understand that Medicare does not cover all chiropractic services. I hereby authorize New Health Chiropractic to release to any insurance company, or their representative, any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of treatment to process my insurance claims.

SIGNATURE _____ **DATE** _____