LAKEWOOD CHIROPRACTIC CLINIC POLICY

OUR OFFICE IS PLEASED TO ACCEPT YOUR INSURANCE ASSIGNMENT, AS SOON AS YOUR EXACT COVERAGE IS VERIFIED BY THE RESPONSIBLE PARTY. WE WILL FILE YOUR CLAIM FORMS AND ASSIST YOU IN EVERY WAY WE CAN. MOST PEOPLE TODAY HAVE HEALTH INSURANCE AND MOST POLICIES COVER CHIROPRACTIC CARE, BUT BENEFITS AND LIMITATIONS VARY WIDELY. IF YOUR POLICY PROVIDES TYPICAL CHIROPRACTIC COVERAGE AND BENEFITS, WE WILL ACCEPT ASSIGNMENT ON YOUR INSURANCE COMPANYS POLICY, WITHIN THE FOLLOWING PROVISIONS AND LIMITATIONS:

1. THE PATIENT'S INSURANCE POLICIES AND BENEFITS MUST BE REVIEWED AND FOUND TO BE ACCEPTABLE TO US.

2. THE PATIENT MUST SIGN OUR PROVIDER/PATIENT AGREEMENT. PROVIDER/ PATIENT AGREEMENT MUS BE HONORED BY THE INSURANCE COMPANIES.

3. PATIENT SHOULD UNDERSTAND THAT THEY ARE RESPONSIBLE FOR CO-PAYMENT AND DEDUCTIBLES ACCORDING TO THEIR INSURANCE POLICY. ***_____(INITIAL)

4. OUR OFFICE DOES NOT GUARANTEE THAT YOUR INSURANCE WILL PAY. WE WILL MAKE EVERY ATTEMPT AT THE BEGINNING OF YOUR HEALTH CARE, TO RECEIVE VERIFICATION OF YOUR POLICY AND WHAT IT COVERS. HOWEVER, IF FOR SOME REASON, YOUR INSURANCE CLAIM IS DENIED, YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF YOUR BILL.

5. OUR OFFICE WILL NOT ENTER INTO A DISPUTE WITH YOUR INSURANCE COMPANY OVER YOUR CLAIM. THIS IS YOUR RESPONSIBILITY AND OBLIGATION.

6. SINCE BY TAKING YOUR INSURANCE ON ASSIGNMENT, WE HAVE TO WAIT FOR PAYMENT, THIS COURTESY MAY BE WITHDRAWN AT ANY TIME IF CIRCUMSTANCES WARRANT.

7. WE WILL BE HAPPY TO COMPLETE DISABILITY FORMS, ATTORNEY FORMS, AND VARIOUS OTHER FORMS FOR YOU HOWEVER YOU SHOULD UNDERSTAND THAT THERE WILL BE A TWO DAY WAITING PERIOD FOR COMPLETION.

8. MATERIAL ITEMS, SUCH AS VITAMINS AND APPLIANCES ARE NOT INCLUDED IN THIS PROGRAM AND MUST BE PAID FOR BY THE PATIENT.

9. WE ARE A MEDICARE PROVIDER. MEDICARE PATIENTS ARE ONLY REQUIRED TO MEET MEDICARES DEDUCTIBLE, PAY FOR X-RAYS REQUIRED BY MEDICARE BUT NOT COVERED BY MEDICARE, AND PAY FOR REQUIRED ADDITIONAL THERAPIES NOT ALLOWED BY MEDICARE. VITAMINS AND ICE PACKS ARE NOT COVERED BY MEDICARE AND ARE PATIENT'S RESPONSIBILITY.
****_____(INITIAL)

10. IT IS OUR OFFICE POLICY TO MAKE CERTAIN THAT WE PROVIDE THE FREE SERVICES PRIOR TO PROVIDING ANY NON-FREE SERVICE AND THE PATIENT AGREES THAT THEY HAVE NOT BEEN COERCED IN ANY WAY TO PROCEED WITH ADDITIONAL NON-FREE SERVICES FOR WHICH FEES WILL BE CHARGED.

11. WE WOULD REQUEST THAT ALL CHILDREN BE ACCOMPNIED BY AN ADULT AND REMAIN IN THE WAITING ROOM WHILE YOU ARE IN THERAPY.

12. IF YOU UNDERSTAND AND AGREE WITH ALL OF THE ABOVE OFFICE POLICIES, PLEASE SIGN YOUR NAME.

_____
PATIENT'S SIGNATURE (PARENT OR LEGAL GARDIAN, IF MINOR).

IN CASE OF EMERGENCY, PLEASE
NOTIFY_____ PHONE NUMBER_____

RELATIONSHIP_____ ADDRESS_____ DATE_____