Financial Policies and Patient Responsibilities

Please Read This Document Completely

* The Center for Total Back Care will bill my insurance as a courtesy. Billing of my insurance company does not guarantee reimbursement from my insurance company.

* The patient/guardian is responsible for all charges incurred in the course of treatment.

* The patient/guardian may request a copy of charges at any time.

* Insurance company reimbursement policies for chiropractic and/or physical therapy vary. This depends upon the policy you and/or your employer have purchased. A call will be placed in an attempt to determine your insurance benefits from your carrier before treatment is rendered. An estimation of benefits by the insurance company is not a guarantee of payment. **It is the patient's responsibility to know what their benefits are. The course of therapy developed for you by your therapist may include procedures that are not covered by your policy. You will be responsible to pay for those procedures not covered by your policy. Please consult your policy if you are unsure.**

* **Pertaining to liens/auto accident injuries/personal injuries:** The patient understands and agrees that as a condition of treatment, that The Center For Total Back Care may have a written contract with the patient's health plan, PPO, HMO, or other Insurer, permitting The Center For Total Back Care, if the medical expenses are accident related, to balance bill the amount of it's normal or customary charges over and above that allowed by the health plan against the patient's Third Party Liability, Uninsured/Underinsured/Medical Payments, or similar no fault insurance. By signing below, the patient reasonably expects to be responsible to pay the amount of the above balance billing from the insurance proceeds. **In these cases, we will file a medical lien as allowed by Arizona state law. Further, the patient consents and agrees to our filing such a lien and will be responsible for all administrative costs associated with the filing of this lien. Because of the risks associated with accepting a lien only arrangement, we do not reduce our bills at the time of settlement**

* Patient co-pays, co-insurance, deductible, and fees for supplies are due and must be paid at the time of service.

* Patient/Guardian grants Power of Attorney to The Center For Total Back Care to deposit check payments issued by my insurer written in two party payee formats.

I understand and have had my questions answered regarding these policies and responsibilities. I acknowledge and agree that I am responsible for any and all portion of my bill not paid by insurance. If under 18 years old, a guardian must be present to sign this agreement before the patient can be seen.

_____ _____

Patient Name Date

_____ _____

Patient/guardian Signature Relationship to Patient

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