Financial Policy

The following is a statement of our financial policy which we require you to read, agree to, and sign prior to any treatment.

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. WE ACCEPT CASH, DISCOVER, VISA, AND MASTER CARD.

- Our clinic has established a single fee schedule that applies to all patients for each service provided.
- You may be entitled to a network or contractual discount under the following circumstances.
- We are a participating provider in your health plan (Blue Cross Blue Shield of IL, PPO)
- You are covered by a State or Federal program with a mandated fee schedule (MEDICARE)
- You are a member of ChiroHealthUSA. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our staff for more information.
- As part of our compliance plan, as of May 11, 2010, our office will be unable to extend any type of discounts other than those listed above.

- **Regarding Insurance:**
- We will be happy to verify and bill insurance and accept assignment of benefits after the second visit, provided that the insured has coverage for the services you are seeking.
- We require that any co-payments or co-insurance payments be made at the time of service.
- Insurance billing is done weekly, provided we have all data to file the claim.
- We will do our very best to facilitate payment from your insurance company.
- To qualify to defer payments to a third party payer (insurance company), a credit application ***must*** be
- completed and signed. Payments must be made in full each visit unless an application is completed and signed.
- Please remember that your insurance policy contract is between *you* and *your* insurance company. We are not a party to that contract, and we will *not* become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges/services, usual customary fees, and etc., other than to provide factual information. If for any reason your insurance carrier denies payment, the balance will then become your responsibility, and payment will be expected within 30 days of the billed notice. Any disputes about unpaid fees should be taken up with your insurance company.
- **A quote of benefits by phone from your insurance company is *not* a guarantee of payment, and all claims are subject for review by your insurance company.**

- **Minors:** The adult accompanying a minor (parent or guardian) is responsible for full payment. Unaccompanied minors will not be treated without express consent of is or her parent or guardian.

- **Additional Fees:** There will be a fee assessed for appointments missed without prior cancellation (we ask for 24 hours notice). There will be a $25 charge assessed for all returned checks. There is a 1.5% monthly late charge assessed on all balances after 30 days past due. *Additionally*, the undersigned agrees to pay a collection fee of 35% of the total owed when sent to collection, and all attorney fees and court costs incurred by the creditor.

I have read, understand, and agree to the above financial policy: _____

Patient or Responsible Party Date

Policy of : Head to Toe Health & Wellness
117 W. Main Street
Peotone, IL 60468

Red Flag Rule

The Federal Trade Commission states that all prospective new patients are required to establish their identity by producing an unexpired driver license or state identification card with a photograph. The license or identification card is examined to determine if it is current and appears to be valid. A photocopy of the license or identification card is made and kept on file. Please present your license or identification card to the receptionist for inspection and then a copy will be made on the back of this form.

Credit Card Information

I agree to allow Head to Toe Health & Wellness to charge my credit card for any balance due.

Name on credit card _____

Credit Card Billing Address_____

Credit Card Billing Zip Code _____

Credit Card #_____

Security code_____ Exp Date_____

Signature of Card Holder_____

Date of Signature _____