

FINANCIAL AGREEMENT HEALTH INSURANCE

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

EXPLANATION OF INSURANCE COVERAGE

Most insurance policies cover Chiropractic care, but this office makes no representation that your does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for Chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance company(ies) in a timely manner.

PAYMENT ARRANGEMENTS

We require that you pay _____% or _____ co-pay of your charges on the day the services are performed. Any unpaid balance will be considered past due.

ASSIGNMENT OF BENEFITS

Attached is an "Assignment of Benefits" form which we would like you to sign. This form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring the full payment to our office immediately upon receipt.

RELEASE OF INFORMATION

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

VOLUNTARY TERMINATION OF CARE

If you suspend or terminate your care at any time, your portion of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately, will be personally responsible for payment, regardless of your insurance coverage.

We hope that this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

Patient's Signature

Date

**ASSIGNMENT AND INSTRUCTION FOR
DIRECT PAYMENT TO DOCTOR**

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Claim or Group # _____

SS# or ID# _____

I hereby instruct the above named insurance company to pay by check made out to and mailed directly to:

*Kirwan Chiropractic
P.O. Box 1538
Allen, TX 75013*

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

C/O

*Kirwan Chiropractic
P.O. Box 1538
Allen, TX 75013*

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Date at _____ County, this ____ day of _____ 20____.

Signature of Policy Holder

Witness

Signature of Claimant, if other than Policyholder

OUR OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will supply you with an insurance verification form. We will file your claim and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

Office Policy Regarding Insurance Assignment:

- Since by taking your insurance on assignment, we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.
- Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you will be held responsible for paying. *If your insurance company does pay and you have a credit balance, it will be refunded to you.*
- You may pay the percentage of service rendered as you go along. (e.g. if your insurance pays 80% of your care, you may pay 20% on each visit) after meeting your deductible.
- We will bill your insurance bi-monthly as long as you are receiving chiropractic care in this office. **We will need a completed health insurance form from your company.**
- You are required to sign an “Authorization to Pay Physician” form and any other assignment documents required by your insurance company on your first office visit.
- 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 your bill.
- You will receive a monthly statement from this office which will include what your insurance hasn't paid and also what is owed by you.
- If you understand and agree with all of the above office policies, please sign your name below and we will accept your insurance assignment.
- If you have any questions, please feel free to ask.

DATE

SIGNATUR