CHOICE CHIROPRACTIC AND WELLNESS CENTER OFFICE POLICY

The following is an explanation of our payment and clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issues – regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account, or insurance coverage.

Patient Payment Policy

We require that you provide credit card information to Choice Chiropractic and Wellness Center. You will not be treated without a credit card on file. The credit card provided will be debited in the event you have any outstanding balance overdue by 120 days. You will receive statements each month via mail and our office will attempt to contact you via phone and email address provided at least 24 hours prior to debiting the card. We will contact you one month prior to the expiration date indicated on the card to obtain updated information.

Credit Card Authorization

By providing the credit card below, I _____, authorize Choice Chiropractic and Wellness Center to debit my credit card in the event I have an outstanding balance that is greater than 120 days.

Visa ___ Mastercard ___ American Express ___ Discover ___ Other ___

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Exp. __ __ / __ __ CVS __ __ __ Zip __ __ __ __ __

Signature _____Date_____

Billing Policy

Patients under care are required to make regular payments on all unpaid balances, except for properly documented Worker's Compensation or auto injury claims. Payments need to be paid in accordance with the arrangements you have made with the front desk assistant. We do charge a 40% interest on all account balances over 120 days for delinquent accounts with a declined credit card. They are also forwarded to a collections agency at that time.

You will receive a monthly statement with all of your charges itemized. Please review these and retain them for your records (taxes, etc.). For questions about your bill, please call, 412-364-9699.

We will not submit claims for non-covered services to any insurance companies or third-party payors under any circumstances. This includes submissions with the intent of obtaining denials. This also refers to maintenance and cash-based services.

Confidentiality

Every employee of this company has been trained to maintain strict confidentiality regarding patient information. For a family member or friend to obtain general information such as your appointment time they must ask for you by first and last name and be able to prove their relationship status with you. If you do not wish any information to be shared please make the front desk assistant aware.
Today most insurance policies do cover chiropractic care. We will be happy to file your primary insurance claim for you and do everything we can to ensure that you receive proper reimbursement; however, we cannot take responsibility for what your health insurance will or will not cover.

Appointments

In order to better serve our patients, we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others.

Emergency or After Hours Calls

In case of an emergency, you may contact the office for a special appointment any time during regular office hours. If you, a friend or family member requires after hour or weekend assistance, you may call the clinic at (412) 364-9699 for special assistance.

Privacy Policy

Some of our treatment rooms are open. If you need strict privacy, please request a private room.

Assignment

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Choice Chiropractic and Wellness Center** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____
(SEAL)
(patient signature)

X_____(SEAL) X_____
(signature of Guardian if applicable) (please print patient name)

Questions and Answers

Your questions about any aspect of your care or account are invited. Please feel free to ask your doctor or any available staff member. We will make every effort to answer you inquires. You can contact us at 412-364-9699 or at www.choicechiropractic.net.

I have read the Choice Chiropractic and Wellness Center Policies and will honor them.

Patient's Signature _____ Date _____

IMPORTANT INSURANCE INFORMATION

Most insurance policies do cover chiropractic care. However, if yours does not, we encourage you to urge your employer or health insurance broker to change your policy to one that does. Your freedom to choose your own health care provider is a fundamental right. Choice Chiropractic and Wellness Center has patient payment plans for those without health insurance. We suggest you do the following:

1. Call your insurance company to determine exactly what coverage you have. Ask what deductible, if any, applies to your policy. Then ask how much of your claim your insurance company will pay.

2. Obtain insurance claim forms, if needed, from your agent or insurance company, fill in the required personal information and bring them to our office. Be sure to write down all information concerning any injury (auto, work related, etc.).

3. When you bring your insurance forms to our office, please ask one of our staff to double-check them. This will help avoid unnecessary errors and give you a chance to ask any questions that you may have regarding your claim.

4. If your policy has a deductible, then we suggest you know if you have an insurance feature for helping with the out of pocket cost (e.g. HSA or FSA). We also require that you keep your account current on at least a monthly basis. Any reimbursement from payments received from your insurance company will promptly be credited to your account.

5. Some of today's insurance policies don't provide the type of coverage that you may desire and larger patient payments will be required. If this is a hardship, ask your doctor the Choice Chiropractic patient payment plan. This will allow you to get the help that you need and pay for it at your own pace.

6. If you are in auto accident or on the job injury victim, we suggest you discuss your coverage with our insurance office. We may well have suggestions that will help you in this regard.

7. You will be asked to authorize Choice Chiropractic to furnish information regarding your case directly to your insurance company and to assign all benefits as a result of the claim. This will expedite its handling.

8. It's a good idea to know your own insurance coverage. However, if you have questions, feel free to ask. Our staff is experienced in insurance claims handling and will be glad to help in any way they can.