Financial Policy

Insurance coverage varies from insurance company to insurance company and from policy to policy. Our office policy is to verify insurance coverage and submit claims to our patients' insurance companies. HOWEVER, IN DOING SO, WE ARE NOT ACCEPTING THE INSURANCE COMPANY AS THE PARTY RESPONSIBLE FOR THE PAYMENT FOR SERVICES RENDERED. YOU, THE PATIENT, ARE ULTIMATELY RESPONSIBLE FOR PAYMENT as follows:

A. CASH PATIENTS must pay in full at the time of the service.

B. HEALTH INSURANCE (including BCBS) PATIENTS must pay deductible amounts, co-payments and /or patient portion at the time of service. The patient is responsible for all charges. If a claim is not paid within 60 days, you are expected to pay in full and wait for reimbursement by your insurance company.

C. WORKERS' COMPENSATION PATIENTS: If the insured (your employer) accepts responsibility within 14 days, the patient pays only for items that probably will not be covered such as supports, nutritional supplements, etc. If the Workers' Compensation Claim is denied, health insurance will be filed.

D. PERSONAL INJURY/AUTO INSURANCE: If the insurance company accepts responsibility within 30 days, the patient pays only for items that might not be covered such as supports, nutritional supplements, etc. If the personal injury claim is denied, health insurance will be filed. **I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

E. MEDICARE PATIENTS: Part B of the Medicare program provides coverage for manual manipulation of the spine for treatment of a diagnosed spinal subluxation. No other chiropractic services are covered, i.e. exams, therapies, or maintenance care. The patient is responsible for the portion not paid by Medicare and/or supplemental insurance. This portion will be determined upon receipt of Medicare and/or supplemental insurance payment to clinic.

** If this claim is being disputed and the patient is being represented by an attorney, a letter protecting our interest is required. If our interests are not protected, payment in full is required at the time of service and any prior charges become payable at the time.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE AND ACCEPT TOTAL RESPONSIBILITY FOR PAYMENT AS IT APPLIES TO MY ACCOUNT.

Date _____ Patient's Signature _____

I AUTHORIZE THE RELEASE OF MEDICAL OR OTHER INFORMATION AND COPIES OF MEDICAL RECORDS TO MY INSURANCE COMPANY, ADJUSTER, AND/OR ATTORNEY.
I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO DR. CASEY P. MOORE FOR ANY SERVICES OR TREATMENT PROVIDED.
A PHOTOCOPY OF THIS AUTHORIZATION IS VALID.

Date _____ Patient's Signature _____