Financial Policy

REGARDING ALL INSURANCE: We cannot promise that an insurance company will pay for your care, even when it is preauthorized. We strongly urge you to contact your insurance company to verify your benefits; sometimes incorrect information is provided to us. We will submit bills to your insurance carrier as a courtesy to you. We will not become involved in disputes between the insured and the insurance company. ***Payment of non-covered services and copayments is expected at the time of service.*** If you have multiple visits in a single week, you may pay at week's end. If we have to send you a bill for your copay there will be an additional $5.00 charge. If you do not have a co-pay, you will be billed in accordance with your insurance benefits. If an insurance company fails to pay for services within ninety days, the undersigned is responsible for payment. Please remember, regardless of insurance of any kind, ultimately you are responsible for your bill.

MEDICARE: ***If you have Medicare, we do not accept assignment so we ask that you pay at the time of service.*** We will bill Medicare and your secondary insurance. Since we do not accept assignment they will reimburse you. Reimbursable care is limited to spinal manipulation and does not include the initial examination and therapies that may be necessary during care.

PERSONAL INJURY: We will bill **your** med/pay insurance or your health insurance carrier. If you choose not to bill your med/pay or health insurance you will be required to pay at the time of service and we will provide you with an itemized receipt. WE DO NOT BILL THIRD PARTY LIABILITY.

WORKER'S COMPENSATION: We must have verification from your worker's compensation carrier or employer prior to your visit.

TIME OF SERVICE FEES: These fees are designed for patients without insurance, high deductibles or patients who choose not to use a third party payer. For services paid in full at the time of service we will give a discount. ***To receive this discount, you must pay in full each visit.***

MISSED APPOINTMENTS: We understand that emergencies happen but if you are unable to make your scheduled appointments please be courteous and call our office. For chiropractic appointments we will not charge you for your first missed appointment, but for every no call-no show appointment thereafter you will be charged $15.00. For massage appointments you will be charged 50% of the total fee without 24 hours advance notice. For Physical Therapy appointments, you will be charged $45.00 for every no call-no show or last minute cancellation. For Alter-G and Exercise appointments a session will be deducted from your package without 24 hours advanced notice. ***Cancellation fees are the responsibility of the patient and must be paid in full before the next visit.*** Insurance cannot be billed for these fees.

RETURNED CHECKS In the event that a check is written to this office and it is returned from our bank due to insufficient funds or the account is closed, I agree to pay for the amount of the dishonored check plus the amount charged by our bank for the returned check.

PREGNANCY LIABILITY: If you are pregnant and choose to receive care, Gilkey Chiropractic Clinic is not liable. Some sources say that massage therapy in the first trimester could pose a risk, but Dr. Gilkey feels differently about that risk. We will treat each patient individually. If there is any information that is vital to your care please inform us. If you sign below, you are assuming all responsibility.

I have read this policy and understand that I am financially responsible for all unpaid balances for my care. In fairness to our patients who do pay for service, after reasonable efforts on our part to obtain payment, we will solicit the services of a collection agency if necessary. I agree that if any costs are incurred in collecting any payments due for professional medical services, I, the undersigned, will pay such cost of collection. These costs include, but are not limited to, collection agency fees, reasonable attorney fees, and court costs.

Patient Signature:____ Date:_____________

PRIVACY ACKNOWLEDGEMENT

I understand and agree to allow this chiropractic office to use my Protected Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed count of the policy and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Privacy Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office. Additionally, I will allow Gilkey Chiropractic Clinic to speak on my patient status when referred to by name by a referral source.

____ ____

Name of Individual (Printed) Signature of Individual

Date signed _________________