OUT-OF-NETWORK INSURANCE BILLING POLICY

Upon the initial visit and upon any changes to the patient's insurance, the patient is responsible for presenting an updated insurance card. It is the responsibility of the patient to make sure that all insurance information given to New Leaf Chiropractic is accurate, current, and includes both primary and secondary coverage.

Failure to provide correct insurance information may result in your insurance company rejecting your claims for failure to obtain authorization, timely filing, or other reasons, resulting in over-the-counter payments not applying to your out-of-network deductible.

Except for Medicare, New Leaf Chiropractic operates on an out-of-network basis with all major insurance companies. To bill your treatment toward your out-of-network deductible, you **must submit a formal request** to the front desk or billing manager. It is your responsibility to verify your coverage and adhere to the restrictions of your plan.

Your insurance is a contract between you, your employer if applicable, and your insurance company. If you have questions in regards to your benefits, please contact your insurance provider and/or your employer's human resource department.

I authorize my insurance company to make payments directly to New Leaf Chiropractic. I authorize the release of any medical information necessary to process claims and/or pursue payments of this account.

Printed Name:_____

Signature: _____ Date:_____

Signature of Parent or Guardian (if patient is under 18) _____

FINANCIAL POLICY

At **New Leaf Chiropractic & Family Wellness**, we understand that the cost of healthcare is a key concern for our patients. Your care is our main priority, but we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy a member of our staff will be glad to assist you. It is your responsibility to inform our office of any patient information changes including name, address, and insurance information.

We are happy to check your chiropractic benefits for you and inform you if there are any additional financial/insurance options. In the event your insurance does not cover you agree to be 100% financially responsible. In the event there is no coverage, high deductibles, or we are an out-of-network provider, we are able to provide you with a written summary statement of your charges so that you may submit directly to your insurance company (aka the Superbill). You are expected to pay in-full at the time of your visit and to assist this we accept cash, HSA accounts, credit cards (MasterCard, Visa, Debit) and personal checks.

When you pay by check you expressly authorize this office (Brothers Buck PC), if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a processing fee of $25 and any applicable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and its terms.

Financial arrangements are valid under your present condition. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify this office prior to your care. Should you discontinue care or be released from further service, at this office, all outstanding balances are due upon notification. Any past due balance not paid **within 90 days** will be reported to the credit bureau and turned over to an attorney or agency for collections. You will be held liable for up to 50% of the balance owed for the collection fees associated with past due accounts. Please keep your account current to avoid any action or blemish on your credit history. We are happy to put pre-2019 physical x-rays on loan, however any x-rays checked out from the office and not returned within 30 days will be subject to a $250 collection fee as these are part of your permanent record at Brothers Buck, PC. Digital X-rays can be emailed with a signed email release for no charge.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions. **I have read, understand and agree to this Financial Policy in its entirety.**

Printed Name:_____

Signature: _____ Date:_____

Signature of Parent or Guardian (if patient is under 18) _____