HENSLEY CHIROPRACTIC

FINANCIAL AGREEMENT

The purpose of this agreement is to clarify the financial aspects of your care here at Hensley Chiropractic. Please ask questions and discuss any financial changes, concerns, or hardships as soon as possible.

Please choose the one that best describes your situation or case type:

- ☐ **SELF-PAY :** (I expect to pay for services myself at the time of service or before.)
  All charges are due promptly at the time of service. Full payment is expected on or before the date of service. You are eligible for self-pay discounts, wellness plans, etc.

- ☐ **INSURANCE:** (I am covered by a private or group insurance policy.)
  You must complete and sign the worksheet on the back of this paper. As a courtesy to you we will attempt to confirm the information you provide. However, please know **that the information we are given by phone or over the internet from your insurance company representative may or may not be accurate**. As such we can only make an estimate of your coverage and benefits. We will know your exact coverage only after we receive an "Explanation Of Benefits" or "E.O.B." for the particular date of service billed. After this "EOB" has been received we will notify you of any additional balance due or overpayment owed to you. It is your insurance company that makes the final determination of your eligibility and benefits. In the event that the insurance company disputes or rejects the claim, or if you, the patient, fails to obtain a required referral, or confirm prior authorization and this office's participation, you will be responsible to promptly pay all charges for the services received.

  (If you are not comfortable with this "estimate only insurance verification" you may pay for your visit in full at the time of service and change your case type to a "self-pay" patient. If you elect this option, we can provide you with a receipt and "super-bill" with which you can then bill and be reimbursed by your insurance company directly.)

- ☐ **MEDICARE:** (I have straight "Medicare" coverage and have not signed over benefits to an HMO or PPO etc.)
  Please refer to the separate "ABN" our staff will provide to you.

- ☐ **PERSONAL INJURY:** (I had a car accident or personal injury and expect payment from another party.)
  Please refer to the separate "personal injury agreement" and "attorney's lien" to be provided.

- ☐ **WORKER'S COMPENSATION:**
  (I was hurt while at work and expect my employer to pay for my care.)
  Please refer to the "industrial injury" handout and agreement to be provided.

MISSED APPOINTMENT POLICY: Adhering to your recommended treatment program is vital to your improvement. If you repeatedly miss scheduled appointments, your benefit will be less. This office reserves the right to charge a missed appointment fee of $20.00 for repeated no shows.

I have read and agree to the above policies:

Patient's name: _____ **Signature:** _____ **Date:** _____

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INSURANCE WORKSHEET

Please complete this worksheet if you have health insurance that may pay for your chiropractic services. Carefully review your policy and/or call your insurance representative to answer the questions below. Since your policy is an agreement between you and your insurance company we are considered an outside third party. Hensley Chiropractic's billing department will rely heavily on the information you provide here.

Your Name: _____Date of Birth: ___/___/_____

Primary Insured's name/ Policy holder's name: _____

Insurance Company's name: _____

Subscriber I.D. # _____ Policy #: _____

If this insurance is provided through work, what is the name of the employer? _____

What is the group # (if applicable): _____

Insurance company's phone numbers: _____

Insurance Billing Address: _____

Does your insurance cover chiropractic care? Yes _____ No _____

Must you seek care from only a certain list of "participating" chiropractors? Yes _____ No _____

Is Dr. Hensley a "participating" doctor on your "list"? Yes _____ No _____

Do you need a medical doctor's referral before initiating care? Yes _____ No _____

What is your **DEDUCTIBLE** Amount $_____ How much of your deductible has been met? $ _____
(This is the amount your insurance company requires you to pay "out of pocket" before they pay any amount.)

What is your **CO-PAY** Amount? Is it a dollar or percentage amount? $_____ or %_____?
(This is the amount you have to pay toward each visit in addition to what the insurance company pays.)

Is there a **LIMIT** on the number of visits, length of time, or total dollar max per year for your chiropractic care?
If so, what are the limits? _____
_____

Acknowledgement & Authorization:

To the best of my knowledge the information above is accurate. If my insurance company denies or does not allow payment as billed, I understand that I am ultimately responsible for the charges incurred by me while a patient at Hensley Chiropractic. As such I will pay any outstanding amount. I will also notify Hensley Chiropractic of any changes in this information or my insurance policy as soon as possible. If payment is through my insurance, I authorize payment be made directly to Hensley Chiropractic.

Signed: _____ Date: _____