KAIZEN HEALTH & WELLNESS FINANCIAL POLICY/DOCTOR'S LIEN: AUTHORIZATION TO PAY DIRECLTY TO DOCTOR

We are committed to providing you the best possible care and are pleased to discuss our profession fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship with you. **Please ask if you have any questions about our fees, financial policy or your financial responsibilities.**

- We are glad to assist you in billing your insurance company, but you're **ultimately fully** responsible for payment.
- We will contact your carrier to verify your insurance coverage, **but this is only an estimate** of what the insurance company will pay unless we receive an actual payment.
- All fees of $45 or less **must** be paid at the time of the appointment.
- After 60 days, any outstanding balance will be due **in full** by you.
- All payments such as co-payments, co-insurance and deductibles are due at the time of service. We accept cash, check and most major credit cards. Fixed co-payments will be collected before seeing the doctor.
- Part of our services to you is to try and contain the ever-rising cost of health care. In an effort to do this, we have implemented a policy of no open billing.
- Most Chiropractic insurance policies do not cover 100% of services rendered. Because of this and the extreme delay in payment common with insurance companies, you will be asked to pay your deductible and your portion of your charges the day the services are rendered.

Our office participates in several insurance plans. Each plan has its own set of rules and regulations. Our office participates in these programs to allow you to reduce your health care cost in this office.

REFERRALS – If your plan requires a referral from your primary care physician, it's **YOUR** responsibility to obtain it prior to your appointment and have it with you at the times of your visit. If you do not have your referral, **YOU WILL BE RESPONSIBLE FOR ALL CHARGES UP TO THE DATE OF THE REFERRAL.** It is then your responsibility to provide us with the referral as soon as possible.

DEDUCTIBLES, CO-INSURANCE & CO-PAYMENTS – By law, we **MUST** collect your carrier designated deductible, co-insurance or co-payments at the time of service. Please be prepared to pay your deductible, co-insurance or co-payments at each visit.

NON-COVERED THERAPIES - In the event that your policy does not cover the cost for therapeutic modalities (i.e. muscle stimulation, ultrasound or hydro therapy) you will be responsible for the cost of those services if they are chosen to be used.

PATIENTS WITHOUT INSURANCE COVERAGE – Payment is expected at the time of services unless other financial arrangements have been made prior to your visit.

MEDICARE – We will submit to Medicare for the Medicare allowed amount. You, the patient, will be responsible for the exam, therapies, deductible and 20% co-insurance, which can be billed to a secondary insurance if you have one.

SIGNED _____

THIS APPLEIS TO TODAY'S VISIT AND ALL FUTURE VISITS.

OUR OFFICE ACCEPTS CASH, CHECK AND MOST MAJOR CREDIT CARDS.

To: **Kaizen Health & Wellness**

IN CONSIDERATION OF YOUR UNDERTAKING TO TREAT ME, I AGREE TO THE FOLLOWING:

AUTHORIZATION TO RELEASE INFORMATION

I authorize the use of my "SIGNATURE ON FILE" on all of my insurance submissions. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. I also understand that if I am accepted as a patient by this chiropractic office, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request.

SIGNED _____

BENEFITS ASSIGNED

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand this chiropractic office will prepare all necessary reports and forms to my insurance company for services rendered to me and I hereby authorize payment directly to Kaizen Health & Wellness from my insurance company, and the payments received from my insurance company will be credited to my account upon receipt. I shall be personally responsible for any unpaid balance to the doctor. I hereby authorize the attending doctor to release any information concerning my examination or treatment. **IF NO INSURANCE IS FILED ON MY BEHALF, I AGREE TO PAY FOR SERVICES AS INCURRED.** Should my account be placed in collections, I will be responsible for all collection fees, including interest at a rate of 8%, attorney fees and court costs.

SIGNED _____

DATE _____