Our Financial Policies

❑ ***About Insurance Coverage and Other Financial Arrangements***

Our commitment to you is the best chiropractic health care possible. If you have insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policies. Chiropractic care is covered under most insurance plans. Most of our patients having health or accident insurance will fall under one of the plans discussed below. We ask that you read the particular plan that applies to your situation. Please do not hesitate to ask if you have any questions. In all cases, you are ultimately responsible for your bill.

❑ ***Group or Individual Insurance Plans***

When possible, we will call your insurance company to verify the benefits available to you. We cannot guarantee what your insurance company will pay, but we will wait for payment on the portion covered by your insurance if we are an in-network provider. By signing below you will be giving us the authorization to release information to your insurance company to properly process your paperwork. We will expect payment from you on any non-covered services, deductibles or co-pay amounts. You must understand and agree that health insurance policies are an arrangement between the insurance provider and carrier. Therefore, you clearly understand and agree that all services rendered to you are charged directly to you and you are personally responsible for payment. We gladly accept check, cash, Master Card, Visa, Discover or American Express. A late fee of $25 per month will appear on any accounts that remain unpaid after 60 days. Delinquent accounts will be handled by an outside collection agency if unpaid after 90 days.

❑ ***Medicare***

Because of the complexity and frequency of change in Medicare policy, a separate form is provided for you. In addition to filing your primary Medicare, we will also file your “medigap” or secondary insurance for you.

❑ ***"On the Job Injury" - Workers’ Comp***

If you are injured on the job, under the Kansas law, you are entitled to seek care from the doctor of your choice. You must first obtain authorization from your employer. If your employer refuses authorization, you are still eligible to receive up to $500.00 in "unauthorized” care. In either case, you must provide us with the name and address of the insurance carrier that will process your claim. If you do not provide this information, payment for services will be solely your responsibility.

❑ ***Personal Injury or Automobile Accidents***

Please notify your insurance agent of your visit to our office immediately. If an attorney is handling your case, notify us immediately. Although you are ultimately responsible for your charges, we will make every effort possible to wait for your insurance to make payment on your account**. If no payment is received within 60 days, or if we must wait for a settlement or a third party payer, a payment plan will be arranged for you. If you terminate care, payment is due immediately. All accounts that have a balance over 6 months will acquire a 14.9% on a monthly basis.**

❑ ***Patients Without Insurance***

Payment is expected as services are rendered unless prior financial arrangements have been made. We are happy to accept your check, cash, Master Card, Visa, Discover or American Express.

❑ ***Secondary Insurance***

Please inform us if you have a second insurance that may provide coverage.

❑ ***To All Patients***

1. We require 100% of the first visit to be paid at the time of service, except for Workers Compensation and Auto Accident cases.
2. **Payment is required at the time of service.** We will be happy to accept your check, cash, Master Card, Visa, Discover or American Express.
3. We need a photo ID for billing and insurance purposes.
4. If you have any questions about your treatment or your bill, please do not hesitate to call or ask. We will be happy to help you.
5. **Late fees of $25 per month** will appear on all accounts over **60** days.
6. All accounts that have **a balance over 6 months will acquire a 10% APR** on a monthly basis.
7. A **$30** charge **plus** all bank charges will be assessed on all checks returned "unpaid" to this clinic.
8. If an account is turned over to collections the patient will be responsible for all fees associated with the collection process, including but not limited to interest charges and attorney fees.
9. If any second or third insurance appeal is necessary, there will be a **$25 charge per appeal** to you as the patient.

Please call at least 12 hours before, or as soon as possible, for cancellations of appointments. We are blocking off time for you and we are turning away other patients to provide services for you. You may be charged $40 for a “no show” which your insurance will not cover and you will be personally responsible for.

If you understand and agree with all of the above policies, please sign your name below.

Patient’s Signature **Patient’s Printed Name** **Date**

New Patient Information

We would like to thank you for choosing us to assist you with your health care needs. Our goal is to make your experience in our clinic as positive and comfortable as possible as well as educational. Consider us as partners in good health!

On this form, you will be asked to provide us with some very important information about you, so that we may properly evaluate your case. Please take your time to be as complete as possible so that we can best assist you in meeting your health objectives. If you have any questions, or are unsure about the information being asked, we will be more than happy to assist you.

What to Expect...On your first visit, we will gather information about you through our examinations and consultation. There will be someone here to assist you in each step along the way. If you are not sure about what we need, please ask. Nothing will be done without your consent and full understanding.

Patient Education...We will be providing you with information and clinical data in the form of literature, personal evaluations and media presentations. These are designed to help you understand your own case and the procedures you will experience in this office. Everything is brief and understandable. It is recommended that you read the material and keep it together for reference during the course of your care.

Chiropractic Education...Just as we need to know about you, we feel that it is important for you to know about us. Chiropractic education currently consists of four years of under-graduate college education in the biological sciences, followed by another four years of Chiropractic education and clinical internship. We are also required to attend many hours of post-graduate education each year for license renewal. In addition, we are frequently involved in various seminars to keep up with the latest health care information. So, rest assured, you are in good hands!

Paperwork and Forms...We have tried to minimize the paperwork in my office. However, there are clinical forms that must be filled out accurately for your health, legal and professional concerns. We ask that you read a form thoroughly before completing it so that you understand it's intent. Please feel free to ask if you have questions**.**

Consent for the use or disclosure of patient health information for treatment, payment or health care operations...

As set forth more fully in our Notice of Privacy Practices, we are required by law to obtain your consent for any use or disclosure of your health information to carry out treatment, payment or health care operations. In our Notice of Privacy Practices, we provide you information about how we can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this consent.

We reserve the right to change the terms of our Notice Of Privacy Practices at any time. If we change our Notice of Privacy Practices, you can review and/or obtain a revised copy at any time.

By signing this form below, you consent to our use and disclosures of your health information for treatment, payment or health care operations. You have the right to request that we restrict how your health information is used or disclosed to carry out treatment, payment or health operations. We are not required to agree with your requested restrictions, however, if we do agree to your restrictions; we are bound to follow them.

You have the right to revoke this consent at any time, except where we have already used or disclosed your health information in reliance of your existing consent. If you would like to revoke this consent, you must do so in writing.

INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

I, the undersigned, acknowledge by my signature, that I am aware of participating Doctor of Chiropractic listed below, that he/she is a licensed chiropractor, and through rare, injury resulting from manipulation may include stroke, death, disc herniation or protrusion, burns and other injuries or complications. I hereby agree to hold Dr. Kim Miley, Miley Chiropractic, PA/Dr. Jeremy Dulin, Dulin Chiropractic, PA and their affiliates free and harmless from any liability, claims, demands or suits for damages from any injury or complications whatever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Waiver and Authorization to Treat to be a binding on and more to the benefit of the respective principals, heir, executors, administrators, successors and assigns includes any and all of my successors and/or heirs. I further state that should complications rise from such agreed treatment with treating Doctor of Chiropractic that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

****Consent to Treat a Minor Child***** *I hereby authorize Dr. Kim Miley/Dr. Jeremy Dulin and whomever they may designate as their assistants to administer treatment, as she/he so deems necessary to my _____, _____(name).*

_____ _____ _____

Signature of Patient or Legal Representative** ***Patient's Printed Name*** ***Date***

******If signed by Legal Representative, please describe the authority of Legal Representative to sign for patient: