

## FINANCIAL POLICY

*We are providing you with this financial policy in writing to clarify any questions of payment that may arise in the future.*

### Updating Personal Information

You need to update your personal information file every time your information changes so we can keep your data as current as possible. We also need to be able to keep in contact with you in the event that the office hours change, the office moves to another location, adds another provider, or makes any other changes.

### Insurance Assignment

At Whole Chiropractic Healthcare, LLC, (WCH), we offer the option of insurance assignment strictly as a courtesy to our patients. As such, our patients must understand and agree to the following:

1. You are considered a cash patient until you bring in your insurance card and this office both qualifies and accepts your insurance coverage.
2. You are ultimately responsible for full payment for any and all services rendered, except when health insurance contract rates apply or when a signed Hardship Agreement with WCH is already on file.
3. Any co-payments and/or deductibles must be paid in full at the time of service. Estimated co-insurance must be paid at the time of service, or you may make arrangements with WCH to deposit a co-insurance "retainer" with the office. Any remaining co-insurance amount must be paid when WCH receives the explanation of benefits (EOB) from the insurer; if you paid more than the amount of the co-insurance, we will apply a credit to your account. If your course of care is complete, WCH will issue a reimbursement within 30 days of receipt of the final EOB.
4. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim. As such, after 90 days of non-payment by the carrier you are solely responsible for payment in full for any outstanding balance. If after 90 days, WCH is paid by your insurance carrier any claim that you had previously covered, you will be reimbursed the balance, or you may apply the balance to future charges.
5. In the event that you discontinue your program of care prior to the doctor's recommendation, you are responsible for payment in full of any outstanding balance, and the courtesy of insurance assignment is immediately discontinued.

We ask that you sign this form at the bottom as acknowledgment that our office has explained the policy to you, and that you understand it and accept full financial responsibility for all services rendered to you at WCH.

### Forms of Payment Accepted

WCH accepts cash, check, Visa, Mastercard, and Discover. Checks returned for any reason will be re-presented, via ReSubmitIt or another service, to your bank account for collection of the amount of the check, plus any applicable fees as permitted by state law. If WCH is charged a returned-check fee by its bank, that fee will also be passed on to the patient. If these charges, plus the original amount, are not paid within 90 days of the original billing date, the account may be forwarded to a collection agency.

### Medicare Policy

Dr. Hyland Robertson is a non-participating provider who does not accept assignment for Medicare Part B. This means that the cost for all services rendered at WCH, as well as your Medicare co-insurance (20%), must be paid by you on the date the service is rendered (provided you have signed the Advanced Beneficiary Notice [ABN] prior to the service being rendered), regardless of whether Medicare will reimburse you, the patient, at a later date. As a courtesy, WCH will bill Medicare and any secondary insurance (electronically when possible); patients must agree that neither they nor their agents will bill Medicare for services rendered at WCH.

Medicare will typically reimburse patients for 80% of the covered services once claims are processed. Any non-covered services will then be billed to you (or to your secondary health insurance, if applicable), unless prior arrangements have been made.

**For Patients Without Insurance Coverage**

At WCH, we believe that a clear understanding of our financial policy will allow everyone to better concentrate on the main issue, regaining and maintaining your health. Therefore, it is agreed between us that payment will be made in full at the time services are rendered.

**Delinquent Accounts**

In the event that a patient stops making payment on his/her outstanding balance for longer than 45 days, he/she will be considered as having a delinquent account and may be dismissed from the practice. These patients will be given sufficient opportunity to find another provider. Before patients with delinquent accounts will be allowed to return for care, they must pay their entire balance in full. Patients who have had delinquent accounts in the past may be required to pay for future visits "up-front," in cash. Patients with outstanding balances may have their account(s) forwarded to a collection agency after 90 days of non-payment.

**Please see our separate policies for auto accident and worker's compensation patients.**

We welcome the opportunity to discuss any aspect of our financial policy. Please contact Laurie Hyland Robertson (410. 305.1331 or LaurieHR@wholechiro.com) if you have any questions.

*I understand this financial policy fully, and hereby agree that if I should terminate care for any reason, my outstanding balance becomes due and payable immediately. I also understand that my account must be kept current in order for WCH services to be continued. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I also authorize WCH to release any of my information required to process insurance claims.*

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Patient Name (please print)	Patient/Guardian Signature	Date
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**ACCOUNT INFORMATION**

**Who is ultimately responsible for this account?**

Full name \_\_\_\_\_ Relation to you \_\_\_\_\_  
 Billing address \_\_\_\_\_ Work/cell phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

To expedite payment(s), unless other arrangements are made, I agree to authorize WCH to use the following credit card (we will notify you before taking this action):

Credit card type Visa  MC  Discover  Full name on card \_\_\_\_\_  
 Card # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Three-digit security code (on back of card) \_\_\_\_\_  
 Authorized signature \_\_\_\_\_ Expiration date \_\_\_\_\_