CHICAGO CHIROPRACTIC & SPORTS MEDICINE

FINANCIAL PAYMENT POLICY

Thank you for choosing Chicago Chiropractic & Sports Medicine. We are committed to the success of your treatment and care. Our payment policy is designed to answer your questions regarding patient and insurance responsibility for services rendered. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes, such as address, name, and insurance information. Please read it and sign the policy. A copy will be provided to you upon request.

Financial Responsibility

Payment is expected for known patient-due amounts, including insurance co-payment amounts and deductibles at the time of service. We will submit your claims as a courtesy and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. All other payments are expected within 30 days of receipt of our billing statement. If you do not have insurance, payment is due in full at the time of service. Our office accepts cash, personal check and credit card.

Cancellation Policy

We expect 24 hour advanced notice for cancellations. If 24 hour notice is not received, you will be charged a fee of $75. These charges will be your responsibility and will be billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

In-Network and Contracted Insurance Providers

We participate in Blue Cross Blue Shield, Aetna, PHCS/Multiplan and Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. A driver's license is also required with *proof of insurance*. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Out-of-Network and Non-Contracted Insurance Providers

We will submit your claim to out-of-network insurance providers. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out-of-network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us. You are financially responsible for the balance of claims that are not covered by your insurance provider.

Non-covered and Partial Coverage of Services

Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Some of our services are self-pay only services and a few of our services we only submit to insurance for a partial service. You are responsible for paying the difference. If you have any questions as to which services are self-pay only and services that may be only partially covered by insurance, please contact one of our office receptionists.

Workers' Compensation or Automobile Accidents

In the case of a workers' compensation injury or automobile accident, you must obtain the *claim number, phone number, contact person, and name and address of the insurance carrier* prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Nonpayment and Outstanding Balances

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If you have an outstanding balance over 60 days and you come in for treatment, we will provide you with a balance statement that needs to be paid in full at the time of service, unless otherwise negotiated.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date