Financial Policy

We want to thank you for choosing Full Body Rejuvenation Center as your chiropractic health care provider. Restoring your health is our foremost objective and passion. Our treatment will always be rendered solely on the base of need. Our fees comply with the "usual and customary" rates for this region.

REGARDING ALL INSURANCE PATIENTS:

We cannot promise that an insurance company will pay for your care, even if it is pre-authorized. We will submit the bills to your insurance carrier, but will not become involved in disputes between the insured and the insurance company. This courtesy will commence as soon as we are able to confirm coverage for chiropractic services and have the proper, signed insurance forms. Payment of non-covered services balances, co-payments and deductibles are expected at the time of service. We strongly urge you to contact the insurance company to verify your benefits; sometimes incorrect information is provided to us. If an insurance company fails to pay for services within sixty days, the undersigned is responsible for payment. Ultimately, you are responsible for all outstanding balances. If the insurance company erroneously pays directly to the insured, the amount must be forwarded to this office within three days.

1. I elect to have Full Body Rejuvenation Center (FBRC) to bill my insurance company for the covered services I receive from FBRC. In the event of non-payment of any deductible, co-insurance and/or co-payment amount as agreed herein, I will be responsible for any amount unpaid by my insurance company for covered services. I additionally understand that I am responsible in full for the amount of any non-covered services as defined under the terms of my insurance benefit contract. I understand that I am obligated to pay for any non-covered services provided by FBRC. Acceptable forms of payment are cash, check credit and debit cards. Payment is due at the time such services are rendered.

2. Insurance does not pay for all services and items provided in this office. Insurance does not pay for supportive or maintenance chiropractic care delivered by a doctor of chiropractic and you are responsible to pay for these services. You acknowledge that you have been told in advance that supportive or maintenance care is not covered and agree to accept and pay for these services. You have the option to decline these services. Payments for these services are due at the time the services are rendered. I understand that my insurance company will not be billed for these non-covered services.

3. Medicare Patients: Medicare does not pay for all services and items provided in this office. Medicare does not pay for supportive or maintenance chiropractic care. Medicare does not pay for examinations, non-spinal manipulation, manual therapy, therapeutic exercises, neuromuscular reeducation or any other therapeutic procedures including physiotherapies or modalities when delivered by a doctor of chiropractic and you are responsible to pay for these services. You acknowledge that you have been told in advance that supportive or maintenance care is not covered and agree to accept and pay for these services.

AUTOMOBILE ACCIDENTS, PERSONAL INJURY, WORKER'S COMPENSATION AND/OR LITIGATION: If your complaint is the result of an occupational injury, personal injury or automobile accident, or if litigation is pending, please notify us. If an attorney is involved, patients are required to sign a Physician's Lien that will be forwarded to the attorney for signature. If you have medical payments coverage (a.k.a. med-pay) it is our policy to bill this insurance directly and we will provide the attorney with a final statement. Any existing balance left after the med-pay has been exhausted FBRC will be paid from the attorney settlement, third party insurance settlement or the patient at the time of the settlement. Since this settlement will be paid directly to the patient from the attorney or insurance company, it is the patient's responsibility to pay immediately in full the outstanding balance to FBRC. I fully understand that all that all treatment billed through Full Body Rejuvenation Center should be paid first.

1. **I understand that I am being treated for injuries sustained in a motor vehicle accident, personal injury and or workman's compensation injury and that failure to keep my appointments may jeopardize the insurance carrier's responsibility for medical costs and/or compensation for pain and suffering.**
2. **I understand that this office is extending me credit for treatment and that if I miss two (2) office visits without a reasonable excuse all bills may be due immediately.**
3. **I understand that if I sever ties with my attorney before settlement or my attorney will no longer represent my case, all bills may be due immediately.**
4. **Once released from care, if my case is not settled within six months I will begin making payments of $25.00 a month to this office toward my bill.**
5. **If my bill is not paid within 10 days after the settlement, my balance will then be doubled.**
6. **I further understand that if my account is placed in collection status for non-payment or forwarded to a collection agency that I will be assessed a fee of 33% of my current balance.**
7. **No bills and/or records will be released until patient balance has a zero balance, as our office is extending our services as a credit until a final settlement is met. Therefore, all medical records and bills are the property of Full Body Rejuvenation Center, until the patient's balance is paid in full.**

MISSED APPOINTMENTS:

In order to provide you and our other patients with the most optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours' notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

In order for you to receive the full benefits of chiropractic care we have put you on a specific treatment schedule. This schedule was designed with your problem in mind. Missed appointments delay the amount of time it takes to correct your problem. For example, if you were prescribed an antibiotic to fight an infection and you were told to take it 4 times a day for 10 days, but instead you only took it whenever you remembered,

what do you think the chances are of you getting better? I would say that your chances of getting better would not be that good. Wouldn't you agree?

If you have a scheduled appointment and for some reason you cannot make that appointment, it is our policy that you make up the missed appointment earlier or later that same day or first thing the next day. Remember, you came to us to help you get well. If you do not come in as you are scheduled, you will not achieve this goal.

Please call us as soon as you realize that you must miss an appointment or you may be charged a missed appointment fee. Monday through Thursday the cancellation fee will be $25.00. Fridays, Saturdays, Holidays and After Hours the cancellation fee will be is $50.00. Cancellations must be made during the business hours from 9:30 a.m. -6:30 p.m. you cannot cancel the same day of the appointment.

Missed appointment fees must be paid before scheduling subsequent appointments. We may request a deposit for future appointments. In fairness to our patients who do pay for service, after reasonable efforts on our part to obtain payment, we will solicit the services of a collection agency if necessary.
I have read this policy and understand that I am financially responsible for all unpaid balances for my care

<u>Patient Acknowledgement:</u>

I have read, understand and agree to the above financial policy. I acknowledge that I am signing this notice voluntarily and that it is not being signed after services have been provided. I have had ample opportunity to ask questions about my financial obligation and other treatment options. I understand I have the right to refuse care and that by signing this form I am fully responsible for all non-covered services. I acknowledge that I have reviewed my coverage options and that I have been told in advance of services rendered what portion of my care I will have to pay for, including non-covered services as described above and agree to make financial arrangements with this office.

_____

Patient Signature

_____

Date

_____

Witness Signature

Date