Stine Chiropractic Clinic, P.C.

Larry L. Stine, D.C., F.A.C.O

117 Redwood Drive, Fredericksburg, VA 22408

SPECIALIZING IN CHIROPRACTIC ORTHOPEDICS AND SPORTS INJURIES

Financial Policies

Our mission is to provide the very best chiropractic care possible. One of the ways we accomplish this is to eliminate potential problems that may detract from the quality of our work. Therefore, we have developed the following financial policies:

We will verify insurance coverage and review benefits with you upon request. **It is the patients' responsibility to keep up with any maximum limitations that the insurance policy imposes.** Keep in mind that verification of benefits is not a guarantee that your insurance company will pay for all services rendered. You may request a copy of your verification page at any time.

As a service to our patients, we will submit your claims to your insurance company for your treatments. **Any unpaid balance that your insurance company has not paid after 60 days will become your responsibility.** Unless otherwise stipulated, the insurance contract is between the patient and the insurance carrier, not between the doctor and the insurance company.

All co-payment or balances determined by insurance **MUST** be paid at time of service unless a monthly payment arrangement has been set up to defer payments.

Co-Insurance (%) vs. Co-Payment ($)

In an attempt to keep out of pocket costs as low as possible for all of our patients, we collect co-insurance at the time of service. The co-insurance is the percentage of the allowed amount your insurance carrier requires you to pay. A copay is a fixed dollar amount that is imposed per visit. Patients will be responsible for this amount each visit. This is not a guarantee that your insurance will only charge this amount to you. It is only our best estimate of the amount you will be responsible to pay.

Monthly Payment Arrangement

This option can be applied to out of pocket expenses including co-pays, co-insurance, deductibles, or non covered services. There is a one-time administrative fee to set up a monthly payment arrangement.

Please inquire with our front desk receptionist for more information.

Insurance

A current copy of the patients' insurance card is required in order to file claims. All services received prior to insurance verification or monthly payment arrangement must be **PAID IN FULL** at the time services are rendered.

If a claim can be submitted to your insurance carrier at a later day, and the insurance pays your claim, any over-payment will then be credited to the patients account.

Should your insurance carrier change during the course of treatment, it is the patients' responsibility to update their insurance information with the billing department. Any claims that must be resubmitted due to non – notification will incur an administrative fee of $2.00 per claim filed.

Any delinquent patient balance will be turned over to our collections division if not paid within 60 days of the final insurance payment, accruing late fees, interest, and court costs. Please see attached contract sheet for further information.

THIS FORM MUST BE READ AND SIGNED IN ORDER TO RECEIVE TREATMENT

Claims for Workers Compensation:

Patients must report the injury to the employer immediately after the incident, and you will need a claim number in order to file medical claims. Your employer may need to fill out information in order to submit claims to the insurance carrier. Workers compensation cases that are denied may then be submitted to health insurance carriers for payment, or be turned over to the patients cash balance. If you wish to appeal a denial, a monthly payment arrangement will be necessary in order to defer payment during appeal procedures.

Claims for Personal Injury:

We will submit personal injury claims to the patient's auto insurance carrier (med pay), 3rd party insurance, or health insurance for treatment.

Due to the length of time it takes to settle personal injury claims; patients will be asked to schedule a monthly payment arrangement. Should patient payments and / or insurance payments result in any overpayment / credits to the account, a refund will be issued after the balance is paid in full.

See our personal injury fact sheet for more information.

Supports and Supplies

In order to deliver electric muscle stimulation in a sanitary manner to all of our patients, it will be necessary to purchase tens pads at the cost of $10 per area of treatment. Tens pads *typically* last 3 months or 10-15 uses. It may be necessary depending on the prescribed treatment plan to purchase additional tens pads. Tens pads will **NOT** be billed to health insurance carriers.

In addition, Dr. Stine may recommend a support or supply that aids in the recovery of injuries. I understand should I decide to purchase said supports and supplies, my insurance carrier may determine that the support / supply prescribed for me is not medically necessary. Further, I agree to pay for this support / supply even if my insurance carrier decides it is not allowable. I will be credited any payment towards the support / supply that my insurance company remits.

Medicare Patients:

I understand that Medicare does not cover the following services when rendered by a chiropractor: exams, x-rays, ice or heat therapy, electric muscle stimulation, ultrasound, and supplies or supports recommended for my condition. The only service covered by Medicare is spinal manipulation as applied by a chiropractor.

Stine Chiropractic does not file secondary insurance claims; however, usually Medicare will forward the claim to the secondary insurance carrier for you.

Consent to Treat Minor

I hereby authorize Dr. Stine and any other staff member he may designate as assistants to administer chiropractic care as deemed necessary to my child for the course of my child's treatment.

Signature: ______________________________

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and our fees for all services fall within the 50th percentile of usual and customary rates for our area as determined by Ingenix, the industry standard. You may be responsible for payment of services administered regardless of any insurance company's arbitrary determination of usual and customary rates.

Referrals

It is the patient's responsibility to obtain a referral when necessary from their primary care provider prior to treatment. I agree to pay in full for all services rendered without the required referral.

Patient Medical Record Requests

Stine Chiropractic Clinic requires five business days to fulfill your request for medical records; the fee for this service is $10.00. For medical record requests that are required in less than five business days a $20 fee is required. An additional $5.00 will be charged per x-ray film copied.

I have read Stine Chiropractic Clinic's Financial and Office Policies. By signing below I agree to all policies set forth by Stine Chiropractic Clinic, P.C. that applies to my account.

____

Signature of Patient **Date**

____

Signature of Responsible Party

THIS FORM MUST BE READ AND SIGNED IN ORDER TO RECEIVE TREATMENT

Stine Chiropractic Clinic, P.C.

Larry L. Stine, D.C., F.A.C.O

117 Redwood Drive, Fredericksburg, VA 22408

SPECIALIZING IN CHIROPRACTIC ORTHOPEDICS AND SPORTS INJURIES

COLLECTIONS CONTRACT

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be 33⅓ of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and /or locating the undersigned, as may be necessary.

The undersigned understands the Medical Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment, the undersigned understand that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with federal "Health Insurance Portability and Accountability Act." (HIPPA)

I, the undersigned, certify that

( ) I **am** an active duty member of the U.S. Armed Forces.

( ) I **am not** an active duty member of the U.S. Armed Forces.

____
Date

____
Responsible Party

THIS FORM MUST BE READ AND SIGNED IN ORDER TO RECEIVE TREATMENT

Stine Chiropractic Clinic, P.C.

Larry L. Stine, D.C., F.A.C.O

117 Redwood Drive, Fredericksburg, VA 22408

SPECIALIZING IN CHIROPRACTIC ORTHOPEDICS AND SPORTS INJURIES

Patient Consent / Acknowledgement

I understand that Stine Chiropractic Clinic, P.C. may use and disclose my protected health information for purposes of treatment, payment and health care operations. A copy of Stine Chiropractic Clinic's Notice of Privacy Practices, which provides information about how the Practice and individuals involved in my care in the Practice, may use and disclose my protected health information, is available in the lobby. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at (540) 898-4100 at Stine Chiropractic Clinic, P.C., 117 Redwood Drive, Fredericksburg, VA 22408.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

____

Patient or Legal Surrogate Date Relationship to Patient

Stine Chiropractic Clinic has my permission to share health and account information with the following individuals:

Name: Relation:

____

____

____

____

THIS FORM MUST BE READ AND SIGNED IN ORDER TO RECEIVE TREATMENT