FINANCIAL POLICY

Do you have a Flex Plan/Medical Savings Account/or Health Savings Account? Yes or No

All of our patients will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it pertains to your particular situation.

CASH/ TIME OF SERVICE DISCOUNT

For uncovered services, payment is due at the time services are rendered, or at the beginning of your care. Cash, personal checks, Visa and Mastercard are accepted. If a true hardship exists, we will be happy to assist you in making financial arrangements via written agreement (authorized by the doctor). Any balance over 30 days old is subject to a service charge. No-Interest is available through www.CareCredit.com. Any refunds for packages (massages, trainings, etc) will be refunded less the full value rate of the services used, and generally expire one year from date purchased, unless otherwise noted.

HEAL TH INSURANCE

Greco Family Chiropractic provides its services directly to you, not your insurance company. You are ultimately liable for your bill. We will verify your benefits & coverage, however the benefits represented to us by your insurance company are not a guarantee of payment. As a service to our patients, we will submit your bills to your insurance company. All co-pays/co-insurances are due at the time of service. You are responsible for your deductible if it has not already been satisfied, and payment plans are available. If you are filing your own claims, we will provide you with an itemized bill.

******IN THE EVENT THAT WE ARE BILLING YOUR INSURANCE COMPANY AND A CHECK IS MAILED TO YOU, YOU MUST FORWARD IT INTO OUR OFFICE WITHIN 7 DAYS SO THAT WE MAY PROPERLY CREDIT YOUR ACCOUNT.**

WORKER'S COMPENSATION

If you were injured in the course of employment, your care should be paid for under your employer's Workers' Compensation insurance. Notify your employer in writing immediately of the accident. Ask for instructions.

1. Obtain the name, address, phone number and adjuster for your employer's Workers Compensation insurance company and notify them that you are treating at our office.
2. Notify our office of the injury and fill out the necessary paperwork for a worker's compensation claim.
3. Make sure your employer has notified and sent a report to their workers compensation carrier.

Completing these few steps will help ensure you get the care and benefits you are entitled.

AUTOMOBILE ACCIDENT/PERSONAL INJURY

If you are injured in an automobile or other accident, you are eligible for benefits under your auto or other insurance policy. You should inform our office immediately if you were involved in an accident. The necessary paperwork must be filled out completely and to the best of your knowledge. **You must furnish our office with your insurance company. name, claim number, adjusters name and phone number within 5 days of your first date of service.** At that time you can inform us of any legal representation you have obtained. We will furnish your attorney with the progress report and information regarding your health as it is needed.

MEDICARE

We do accept assignment for Medicare; therefore all reimbursements will go directly to our office. As a courtesy to you, we will submit your bills to Medicare. It has been our experience that Medicare usually reimburses 80% of your costs. There may be a coinsurance or deductible associated with your Medicare plan if you do not carry a secondary insurance.

I have read and understand the financial policy of GRECO FAMILY CHIROPRACTIC. In the event my insurance company does not pay the charges I have incurred at this office, I agree to pay any and all fees accumulated within 90 days of the date of service.

_____

Patient's Signature (Guardian if Patient is a Minor) **Date**

_____

Print Name

Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and
Consent for Use of Health Information

Name _____ Date _____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a **full** copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____
(Month, Day, Year)

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____
Signature of Parent / Guardian (circle one)

Furthermore, the he or she does consent to the release of his or her health records to the undernamed family members. Records are including, but not limited to billing statements, insurance inquiries, appointments, and condition diagnoses.

List individuals' names here:

_____

_____

_____

www.grecofamilychiro.com
(215) 675-8009

X-RAY RELEASE

All Patients Please Read and Sign:

I, _____ (Print Name), do hereby give my consent to Greco Family Chiropractic and its representatives to take X-Rays as deemed appropriate by the examining Doctor of Chiropractic. I also hereby declare that to my knowledge; I am NOT pregnant.

_____ _____

Patient's Signature Date

Patient Billing Acknowledgement Form of Non-covered Services

Under your health plan, you are financially responsible for co-payments, co-insurance balances, and deductible claims for covered services. In addition to these payments, you are also financially responsible **FOR ALL NON-COVERED SERVICES DEFINED BY YOUR HEALTH PLAN CONTRACT**. For example, this may include items and services such as supplies/products, therapeutic activities, doctor consultations, **AS WELL AS care that is determined to be maintenance/elective, or care that exceeds your benefit limits.**

While being treated for a chronic condition, you may **elect** to receive care beyond that which is determined to be medically necessary. You may also choose to receive **maintainance** care once the maximum benefit from treatment has been reached. ***Maintenance/Elective Care*** is defined as treatment that does NOT significantly improve a clinical condition. If, during the course of your maintenance/elective care, you develop a new condition– or a previous condition becomes significantly worse– your care may no longer be considered as maintenance/elective and may be covered by your health plan. Your provider must submit a request for additional insurance coverage.

Please understand that this form is not a notice of denied coverage from your insurance company. However, it is your acknowledgement that if the products or services submitted to your insurance company are denied, you are financially responsible for the full or remaining balance.

The services or products listed below may not be covered according to your health plan. Your signature at the bottom of the document indicates that you have been advised of this information and that you agree to pay our "Time of Service" prices for the listed services or products.

Services that may be provided during your treatment process:

- Doctor's New Patient Consultation - **$75**
- Re-evaluation Office Visit - **$20**
- All Therapeutic Procedures - **$10/session**
  - Muscle Stimulation with Heat/Ice
  - Cold Laser/Multi-radiance Laser Therapy
  - Intersegmental/Cervical Traction
- Massage Therapy - **$65/hour**
- Cervical Support Pillow - **$55**
- X-rays - **$40**
- Chiropractic Manipulative Therapy - **$40**
  - Posture Pump
  - Hydrotherapy
  - Ultrasound Therapy
- Orthotics - **$249**
- Other Supplies/Products – **(Prices available at front desk)**

Patient Signature: _____ Date: _____