OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis with a credit/debit card arrangement on file. Any such plan or arrangement will be discussed during your financial care plan visit.

INSURANCE

1. We accept assignment for Blue Cross Blue Shield as a courtesy to you with the following exceptions and regulations provided that we have prior certification from your insurance company. For those insurance companies which we do not accept assignment we will verify your insurance benefits as a courtesy to you.
    a. I authorize Live Well Chiropractic LLC. to verify my insurance benefits
2. You are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
3. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into this office upon receipt. If any overpayment exists after all insurance billing has been done, we will issue you an overpayment check- it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
4. Any services not covered or coverage reductions by your insurance will be your responsibility.
5. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disrupted claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
6. If the patient is referred to another specialist or discontinues care for any reason, their account balance is due and payment in full is required immediately.
7. If you have questions concerning this or any other matter, please speak with the front desk prior to seeing the Doctor.

8. Patients may be refused services based on the following criteria: Any patient not on a pre-arranged payment plan with an account balance of $250 or greater must pay for that days services at the time they are rendered. This patient must also make a payment arrangement for the outstanding account balance.

I authorize and instruct ClearGage, LLC (my Provider's billing administrator) to obtain and review my RiskView(TM) Report from LexisNexis, which Report draws upon public records and proprietary data sources of LexisNexis. I understand that this RiskView(TM) Report will assist in the evaluation of my creditworthiness, may be used to obtain credit and payment history, and may be used to verify my past credit or payment history information. I understand, agree, and hereby give my consent that: (1) my Provider will provide information about me, including my name, address, phone and cell phone numbers, age, birthday, sex, and Driver's License number to ClearGage, LLC, which will provide said information to LexisNexis, (2) information derived from this RiskView(TM) Report will be shared with ClearGage, LLC, my Provider, and third party lenders; (3) information derived from this RiskView(TM) Report will be used in the determination of whether my Provider will offer me a payment plan; (4) my authorization for the RiskView(TM) Report is not an offer of a payment plan and is not a guarantee of any such offer. Likewise, my consent does not constitute my agreement to any payment plan or payment terms; and (5) if I am offered a payment plan, at that time, the terms will be disclosed to me and I can choose whether to accept or reject it. I understand that I may request a copy of my RiskView(TM) Report by writing LexisNexis at: LexisNexis Risk Solutions Bureau LLC RiskView Consumer Inquiry Department P.O. Box 105108 Atlanta, GA 30348-5108 866-897-8126

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

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Patient’s Signature Date