

## **FINANCIAL POLICY**

Chiropractic is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy *as it applies to your particular situation*.

**PATIENTS WITHOUT INSURANCE** We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been pre-arranged and agreed upon. A payment plan can be established in writing.

**GROUP OR INDIVIDUAL INSURANCE** When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

**“ON THE JOB” INJURY (Worker’s Compensation)** If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

**PERSONAL INJURY OR AUTOMOBILE ACCIDENTS** Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

**MEDICARE** We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

**SECONDARY INSURANCE** Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

### **INSURANCE ONE TIME AUTHORIZATION**

*I understand that my insurance is an arrangement between myself and my insurance company, NOT between Dr. Erickson and my insurance company. I request that Erickson Chiropractic Health Center, P.A. prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Kenyon L. Erickson, D.C., that fees will be due and payable immediately.*

Erickson Chiropractic Health Center, PA  
Dr. Kenyon L. Erickson, D.C., F.A.S.A.

Assignment of Benefits

*I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Erickson Chiropractic Health Center, P.A. / Dr. Kenyon L. Erickson, D.C.*

Release of Information

*I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.*

Payment Agreement

*I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.*

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**ERICKSON CHIROPRACTIC HEALTH CENTER, PA (EHC, PA) PRIVACY POLICY**

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations. You may revoke this consent at any time by notifying EHC, P.A. in writing, except to the extent EHC, P.A. has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosures that EHC, P.A. may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request EHC, P.A. to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. EHC, P.A. is not required to agree to requested restrictions. If EHC, P.A. agrees to the requested restriction, EHC, P.A. will honor the request and it will be binding on the office.

*I hereby consent to the use and disclosure by Erickson Chiropractic Health Center, P.A., its workforce, and its business associates of my protected health information for the purposes of treatment, payment, and health care operations.*

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Guardian Signature Relation to Patient Date

Erickson Chiropractic Health Center, PA  
Dr. Kenyon L. Erickson, D.C., F.A.S.A.