

Rivano Chiropractic Health Center, L.L.C.

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FINANCIAL POLICY

We are committed to providing you the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibilities.

MISSED APPOINTMENT(S):

Unless canceled at least 24 hours in advance or filled by another patient, our policy is to charge \$35.00 per missed appointment. We will not file, nor will insurance plans pay for this charge, so please help us serve you and our other patients better by keeping scheduled appointments or canceling in advance.

In order to comply with your recommended care plan, it is advised to reschedule any missed appointments within 24 hours of your original appointment time.

UPDATING PERSONAL INFORMATION

You need to update your personal information on file every time your information changes so we can keep your data as current as possible. We also need to be able to keep in contact with you in the event that the office hours change, the office moves to another location, adds another provider, or makes any other changes.

REFERRALS - If your plan requires a referral from your primary care physician it is **Your** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, **You Will Be Responsible For All Charges Up To The Date Of The Referral**. It is then your responsibility to provide us with the referral as soon as possible.

DEDUCTIBLES & CO-PAYMENTS/CO-INSURANCE - By law we **MUST** collect your carrier designated co-payment/co-insurance at the time of service. Please be prepared to pay deductible or co-payment/co-insurance at each visit. If payment is made with a personal check and returned due to insufficient funds you are responsible for immediate remittance of the balance as well as a \$35.00 returned check fee made payable directly to our office.

NON-COVERED THERAPIES - In the event that your policy does not cover the cost for therapeutic modalities (i.e. muscle stimulation, ultrasound, etc.) you will be responsible for the cost of those services if they are chosen to be used. We will always do our best to let you know if something is not going to be covered in advance based on the insurance verification provided by your carrier.

We cannot guarantee payment as we are not the insurance carrier. However, as a courtesy we will verify your coverage. However, misinformation occurs regularly when verifying health benefits and cannot be a guarantee of coverage. It is ultimately **YOUR** responsibility to understand your coverage. If claims are delayed by more than 90 days, we require you to reimburse our office in full for services rendered. **The Patient Is Liable For Any And All Expenses Incurred In This Office.**

PATIENTS WITHOUT INSURANCE COVERAGE - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE - We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the exam, therapies, deductible and 20% co-insurance which can be billed to secondary insurance if you have one. X-Ray's if needed will be done at an imaging center that is convenient for you. A prescription will be provided for you to take with you to your appointment.

**THIS APPLIES TO TODAY'S VISIT AND ALL FUTURE VISITS.
OUR OFFICE ACCEPTS CASH, CHECKS, MASTERCARD AND VISA**

IN CONSIDERATION OF YOUR UNDERTAKING TO TREAT ME, I AGREE TO THE FOLLOWING:

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

SIGN _____ **DATE** _____

BENEFITS ASSIGNED

I hereby authorize payment directly to the Rivano Chiropractic Health Center, L.L.C. for professional services rendered and I shall be personally responsible for any unpaid balance to the Doctor. I hereby authorize the attending Doctor to release any information concerning my examination or treatment.

SIGN _____ **DATE** _____

DELINQUENT ACCOUNTS

In the event that a patient stops making payment on his/her outstanding balance for longer than 45 days, he/she will be considered as having a delinquent account and may be dismissed from the practice. These patients will be given sufficient opportunity to find another provider. Before patients with delinquent accounts will be allowed to return for care, they must pay their entire balance in full. Patients who have had delinquent accounts in the past may be required to pay for future visits "up-front," either in cash or by credit card. Patients with outstanding balances may have their account(s) forwarded to a collection agency after 90 days of non-payment.

Collections of Past Due Balances - Any past due balance not paid **within 90 days** will be sent over to an attorney or agency for collections. You will be responsible for all charges related to this collection process. Please keep your account current to avoid any action. Statements are sent out on a monthly schedule for patients who have balances. The due dates are clearly posted on the statement. If payment is not received by the due date then a 10% late fee will be assessed and applied to your balance.

FINANCIAL HARDSHIP

In certain instances if you are unable to afford your care special arrangements can be made to provide you with a payment plan that will allow you to continue your care.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions. I have read, understand and agree to this Financial Policy in its entirety.

SIGN _____ **DATE** _____