Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to understand our financial policy.

Most health and accident insurance companies cover chiropractic care. Keep in mind that your insurance policy is a contract between you and your insurance company.

If you have insurance, we will call your insurance company to determine your coverage for chiropractic care. However, information provided by phone (or written in an insurance policy book) does not guarantee the payment of benefits. Insurance companies cannot establish whether benefits will be paid until an actual claim is submitted. We cannot take responsibility for knowing which services your insurance company will or will not cover. Not all insurance plans cover all services.

Ultimately, you are the party responsible for payment for all health care services we provide to you at our clinic. As a courtesy to you, we will gladly submit to your insurance company invoices for services we provide to you.

We have made in-network arrangements with some insurance companies. For patients who have policies with these companies, we will bill the insurance company and collect the required co-payment or unmet deductible balance at the time of your visit.

If you are insured by a company with which we do not have a prior arrangement, we will submit the claim for you. However, payment for your care is due at the time of services.

PAYMENT RESPONSIBILITY

I will pay all co-payments or unmet deductible balances at the time of services.

I understand that I am personally responsible for any remaining balance this clinic does not collect from my insurance company. In the event my insurance company does not compensate your clinic within thirty (30) days after billing, I will pay the remaining balance.

I understand that there will be a $29 PER 30 DAYS charge on all unpaid balances, if payment arrangments aren't made.

I have read and understand this financial policy and agree to be bound by its terms.

Signature/Date of Patient or Responsible Party

Signature : _____ Date: _____

Lifeline

Dr. Gregory K. Penniston

CHIROPRACTIC & APPLIED KINESIOLOGY P.C.

Agreement for Record Release and Payment

I authorize you to release medical records to my family doctor and/or to my prescribing physician, and to release any medical information necessary for processing insurance claims. ____ (initial please)

I hereby authorize assignment of my Medicare/Insurance benefits to you. I will be responsible for any difference (balance) that my benefits do not cover. I acknowledge full financial responsibility for health care services. I agree to pay my bill in full at time of service or make arrangements for payment. If my bill must be placed for collection, I acknowledge responsibility for associated collection expenses in addition to the regular fees for medical services. In the event action is brought hereof, the prevailing party shall be entitled to recover from the other party the court costs and attorney fees determined and awarded by the court. If this account is referred for collection, I/we agree to pay collection fees up to 50% on the balance owing. If legal action is deemed necessary, I/We agree to pay reasonable attorney's fees and court costs in addition to the above costs. _____ (initial please)

I understand that Medicare does not pay for exams, x-rays, supplements, or supplies. If the doctor suggests any of the above for my benefit and treatment, the charge will be billed to my account and become my responsibility. _____ (initial please)

It is our office policy that we do not bill Medicare for auto accidents. Please notify us if this is the case and we can help you make other arrangements. ____ (initial please)

For patients with liens only: An administrative charge of $80.00 will be added to your account to help set up liens other than those filed with an attorney. This charge helps to offset the fee we have to pay for the lien to filed with Pima County. ____ (initial please)

Date: _____ Signature: _____

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