Notice of Financial Policy

Please carefully review the following policies regarding our financial practices pertaining to the collection of payment for the services provided at our office. Although we make every attempt to provide you with accurate information regarding your insurance benefits and coverage for all our services, we CAN NOT GUARANTEE your benefits will provide coverage for all of our services. **You insurance is a contract between you, your employer, and the insurance company; we are not a party to that contract. We must emphasize as health care providers, our relationship is with you and not your insurance company.** We ask that you also become familiar with your insurance policy by calling the Member Services phone number located on your insurance card or by logging in to your insurance company's website.

_____**MEDICARE:** Medicare provides chiropractic coverage for SPINAL ADJUSTMENTS ONLY. X-rays are not covered and will be a separate charge. Medicare patients will be required to sign an Advanced Beneficiary Notice (ABN). This form will explain which services Medicare may not cover and that you may be responsible for those charges.
ABN (Advanced Beneficiary Notice) Signed Yes ❒ No ❒

_____**MEDICAID**: We accept CARESOURCE and Medicaid card.. ODJS allows 15 chiropractic treatments per calendar year. Payment for any additional treatment will be the patient's responsibility.

_____**WORKER'S COMPENSATION:** We are a certified Ohio Worker's Compensation provider. Only active, allowed claims are eligible for treatment authorization requests. ALL TREATMENT MUST BE PRE-APPROVED. We require a secondary insurance in the event treatment is not authorized through Worker's Compensation. If you have no other insurance we will make every effort to arrange a comfortable payment schedule.

_____**AUTO ACCIDENTS/PERSONAL INJURY:** If you have been involved in an auto accident we will bill treatment for your injuries to YOUR AUTO INSURANCE. If you have comprehensive coverage (not just liability) you have "medpay" coverage. We will need to verify how much medpay coverage is available. If you were not the at-fault party your insurance company will recover any money paid from the at-fault party's insurance company. We will honor a LETTER OF PROTECTION from you attorney until 6 MONTHS AFTER THE LAST DATE OF TREATMENT. If we have not received payment after 6 months we will bill your auto insurance medpay. If you do not have medpay benefits we will bill your private health insurance or make a comfortable payment schedule.

_____**GENERAL HEALTH INSURANCE:** We are IN networks with the following major health insurance providers: Anthem BC/BS. Medical Mutual of Ohio, Aetna, Cigna, United Health Care. Also, please be aware of any deductibles and co-insurance that you may owe. Chiropractic services are typically reimbursed as a SPECIALIST or PHYSICAL THERAPY. Therefore, your co-pay may only apply to the initial office visit. Co-insurance and deductibles are calculated by your insurance company and reported to us on your explanation of benefits. Once we are notified, we will add the appropriate charge to your account and send you a statement, payable upon receipt.

_____**NO COVERAGE/SELF PAY**: We do not have alternative payment options if you do not have insurance that provides chiropractic benefits or if you have no insurance at all. We will customize a cash payment plan based on your individual treatment plans. Pre-pay, Monthly, or Pay as you Go are available based on your needs and frequency of care.

Massage Therapy Services, Spinal Supports, Pillows, Retail Goods, and all other non-physician provided services are NOT BILLED TO YOUR INSURANCE and payment is required at the time of service/purchase

Please remember your overall health needs are our NUMBER ONE priority here. We will not turn you away because you are underinsured or uninsured. We understand financial strains and will be respectful of your decisions to alter you recommended treatment plans to accommodate your payment responsibilities.

By signing below I acknowledge that I have read and understand the Financial Policies of Pickaway Chiropractic Center and that I am responsible for arranging payment of all services provided to me at this office.

Patient Signature (or Parent of Minor)_____Date _____