OFFICE FINANCIAL POLICY FOR TRI-MED HEALTH AND WELLNESS CENTER, P.C.

WELCOME TO TRI-MED!

Our physicians and staff are dedicated to providing you with high quality chiropractic care. Your clear understanding of our office financial policies is an important part of the excellent service we strive to provide each and every day. Should you have any questions regarding our fees and policies or your rights and responsibilities, please feel free to speak to a member of our billing department for further clarification.

ACCIDENT/INJURY DENIAL

If your condition is related to an auto accident, personal injury, or worker's compensation claim please skip this section.

I, _____, hereby state that my current condition is not related to an auto accident, worker's compensation claim or other incident in which I may file a claim against an insurance company other than my own medical insurance. _____ *Initial denial if this is NOT an accident claim*

PERSONAL INJURY/AUTO ACCIDENTS

We accept med pay/PIP, third party payments, and personal medical insurance on auto and PI cases. You are required to provide all claim, contact, and billing information for your case before the start of your care. We reserve the right to refuse to bill for services if you fail to provide us with this information before your timely filing deadlines. Not providing full and accurate billing information in advance may cause you to be liable for the cost of your care.

If you elect to bill your medical insurance for any services where another party may be responsible for the cost of your care, you will be expected to negotiate any required reimbursements with your insurance company directly.

If payment for a personal injury claim or auto accident is made directly to you for our services, you agree to reimburse our offices for the full balance of your account within five (5) days of your receipt of the settlement. It is not the practice of this office to offer reductions for care rendered in third party injury cases.

WORKER'S COMPENSATION

Worker's compensation cases must have an open claim with an authorization on file to receive care. You are required to present this information along with the contact and billing information for your claim prior to care being administered. Denied claims that are within timely filing limits may be submitted to your primary medical insurance. If your primary medical insurance denies your claims, you will be responsible for the full cost of your care.

INSURANCE

In order to properly bill your insurance company, you must provide your insurance information in full. Once your information is received, our staff will provide you with a report of your chiropractic coverage. This is not a guarantee of payment. We are in no way responsible for the benefit information provided by your insurance company and any balance that results from a denial of service for any reason is ultimately your responsibility. We encourage you to discuss your concerns regarding coverage denials directly with your insurance company.

It is the patient's responsibility to obtain any referrals or authorizations required by the insurance company prior to their appointment. Services that are denied due to lack of referral or authorization on file will be the responsibility of the patient.

At your request, we will bill your primary insurance company for covered services only. We are in network with several commercial and state insurance plans. We are not obligated to accept any discounts or write offs from plans if we are not a contracted provider. Ask the billing department if you have questions regarding our current balance billing policy and/or a list of our current in network plans. We reserve the right to discontinue our in network status with any plan at any time. We will make every effort to notify you of any changes to our network status with your insurance company in advance.

_____ Initial to indicate you have read and understood the front page, then turn over to sign and complete.

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SELF PAY, NON-COVERED SERVICES, DEDUCTIBLES, CO-PAYS, AND CO-INSURANCE
Please be aware that any amounts due from the patient are expected at the time of service or as specified by an authorized payment plan. Please ask to speak to our billing staff if you would like to set up an authorized payment plan that will meet your budgeting needs. You may not carry a balance of more than $200 without an authorized auto debit plan on file.

MEDICARE/MEDICAID PATIENTS
We accept assignment of benefits from Medicare and from Iowa State Medicaid. As a Medicare and/or Medicaid patient, your signature on this form certifies that the information supplied by you is correct. Your signature also authorizes any holder of any information about you to be released to the Social Security Administration or its intermediary carriers for this or related Medicare/Medicaid claims.

RESPONSIBLE PARTIES AND MINORS
Financial obligations are the responsibility of the patient receiving the service as long as that patient is of age. The adult who presents a minor child for care accepts responsibility for payment at that particular date of service. We will not act as an administrator to resolve financial arrangements. Bills will be directed the parent on account and both parents are considered legally responsible for any account balances.

STATEMENTS AND BILLING
Statements are sent once per month to the responsible party on account. Payments will be accepted in person, by mail or by phone from any party who wishes to pay on an account but PHI will remain confidential at all times. Payment of services for another party does not warrant access to their PHI at any time. Accounts are expected to be paid in full within 30 days. Account balances which exceed $200 are not allowed without an authorized auto debit plan and payment plan on file with our office. Failure to pay accounts in a timely fashion or to establish the appropriate payment measures for accounts will result in collections or legal action. Accounts that have received 2 or more statements may be submitted to collections or be subject to legal action.

RELEASE OF INFORMATION
Please list the names and relationship of any party to whom you agree we may release your personal health information. This information includes confidential medical and billing details which are covered in detail in our current HIPAA policy. You may request a copy of this policy at any time.

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I have read the above financial policy, understand it fully, and agree to adhere to those policies.
For insured patients: I hereby authorize payment directly to the provider of any and all benefits for charges for services received by myself or my dependents. I authorize benefit payers to release any and all information requested regarding such benefits and payment to the provider above. I also authorize the above provider to release medical and other information as may be required to obtain benefits for charges for services provided to myself or my dependents.

_____ _____
Patient/Guardian Signature Date

Print Name_____

Witness_____

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