More Than Just Adjustments

515 Hamilton Street
Geneva, IL 60134
Phone: 630.232.7611

Financial Policy

If you would like our office to bill your insurance, please provide your credit card information below. Your card will be kept on file but not charged without prior notification. Without a card on file, payment is due in full at the time services are rendered.

Credit Card #: _____CVC: _____ Expiration Date: _____

Cardholder Signature: _____ Date: _____

Please initial the billing option below that you agree to follow:

_____ Private Pay: I will pay for all services, as they are rendered, and submit my own insurance claims.
_____ PPO/Preferred Provider Organization: You are in my PPO network. I am responsible for any co-payment, deductible, and non-covered services, according to my plan. I will pay the co-payment, deductible, and non-covered services that I am responsible for, as laid out by my plan.
_____ HMO/POS: My primary care physician (PCP) has agreed to authorize a referral to your office. It is my responsibility to make sure that the number of visits authorized remain current. I understand that I am responsible for, and will pay, whatever co-payment and non-covered services that my plan sets forth.
_____ Medicare: I'm a Medicare participant and I understand that Medicare only pays for spinal manipulation procedures at 80% of their approved amount, and only after my yearly deductible has been met. Our office will bill Medicare directly. Medicare should then reimburse our office at 80% of the spinal manipulation fee. Any supplemental policy should also reimburse our office, according to the benefits allowed by that policy. If I have a supplemental policy, it may cover the 20% of the portion of the spinal manipulation fee not paid by Medicare, and/or some percentage of any other procedures (besides spinal manipulation) not covered by Medicare. Regardless of my insurance coverage, I understand I'm ultimately personally responsible for the balance of all charges for all services rendered.
_____ Worker's Compensation: I was involved in an injury at work. I will see to it that all appropriate paper work is filed by my employer (i.e. accident report, etc.). I understand that it is my right to have any bills incurred as a result of a work-related accident paid for. If after 60 days my claim is not paid, I will personally pay the overdue balance. I understand that if this is the case, my rights may have been violated and I have the option to seek legal counsel.
_____ Auto Accident/Personal Injury: I was involved in an automobile accident/personal injury and would like to have you submit all charges to my insurance company for me. I will sign all liens necessary to protect your office. If the first insurance payment is not received within 45 days of my first date of service, I agree to pay $100.00 per month while your office awaits final payment. I will be promptly reimbursed should any overpayment occur on my account. I understand that regardless of payment arrangements, I am personally responsible for the entire balance within 90 days of completion of care.

I agree to provide at least 24-hours notice if I need to cancel or reschedule any appointment. I agree to pay a $40.00 missed appointment fee for each appointment for which I fail to provide appropriate notice. I acknowledge that I am responsible for any collection agency fees should I fail to make payment of outstanding balances that are my responsibility. I agree to pay the 30% collection fee of the total balance due that will be added to my account balance if the account is placed with a collection agency due to non payment.

Signature: _____ Date: _____

Authorization (to release information & settle insurance appeals or disputes)

I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the doctor(s) at Partner in Health to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the doctor(s) in Partner in Health and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor(s) in Partner in Health in any attempts by such doctor(s) in Partner in Health to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor(s) in Partner in Health against such insurers and/or employee health care plan in my name but at such doctor(s) in Partner in Health expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Patient/Guardian: _____ Date: _____

Signature of Insured (If Different): _____ Date: _____

Assignment (of benefits to doctor)

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Partner in Your Health, S.C. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor(s) in Partner in Health. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

Signature of Patient/Guardian: _____ Date: _____

Signature of Insured (If Different): _____ Date: _____