Authorization, Financial, and Office Policies

Please initial next to each statement, indicating that you give authorization.
Some statement may not apply to you specifically, but are part of our office protocols.
Updated 01/01/2023

Release of Information
I hereby authorize Life Line Chiropractic to release my medical and financial data to my insurance company and/or attorney.

Protected Health Information
I give permission for Life Line Chiropractic to use my address, phone number, and clinical records in order to contact me with appointment reminders, notifications, birthday/holiday related cards, possible alternative treatment options, and/or health related information.

I give permission to disclose protected health information in the presence of anyone accompanying me into a treatment room or consultation room by my request.

I give permission to disclose protected health information to any other specialist, if deemed necessary in further treatment of my care. This is to include the release of my medical records, photo identification, and insurance information.

I understand certain times treatment could be rendered in open room areas, where other patients are also being treated. I am aware other patients in the office may overhear some of my protected health information during the course of my care. Should I need to speak to the doctor and/or staff privately, the opportunity will be given for a private conversation.

I give permission for Life Line Chiropractic to send, by mail or fax, any of my protected health information that is necessary for treatment, payment, and/or further services.

Responsibility of Bill
I understand that payment must be rendered at the time of service, unless prior arrangements have been made.
accept full financial responsibility for charges and services rendered to me as a patient.

I understand that services are rendered and charged to the patient. Services are not charged to the insurance company, only billed to the insurance company. Life Line Chiropractic cannot accept total responsibility for collecting an insurance claim, nor negotiating a disputed settlement.

I understand that billing the insurance company is not a guarantee of payment, and that I am fully responsible for the outcome of any remaining balance.

I also agree that this obligation shall exist regardless of private contractual agreement between the myself and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance, for which payment is denied through any utilization review or precertification procedures. I also understand that if I suspend/terminate my care and treatment, the fees for services rendered to me will immediately be due. In the event of default I will pay legal interest on the indebtedness, along with collection costs and reasonable attorney fees that may be required for collection.

Insurance filing is not a mandatory procedure it is a courtesy to our patients. We will do all that we can gather the information regarding your policy and coverage. However, it is ultimately up to you to understand your insurance policy and its coverage. Having insurance still does not guarantee of payment, and all balances due on the account after filing is complete will be due by you, the patient unless other financial arrangements have been made.

Subrogation and Rights of Reimbursement Agreement
If I, or a covered dependent, receive benefits under my health insurance carrier, hereinafter referred to as carrier, due to an injury or illness as a result of the acts of a third party, I agree to repay the carrier any amount of money that I receive for third party of its insurer as compensation for such injuries up to the amount paid out by carrier. I understand that this includes the insurer, other agent, or if I enter into an form of settlement regarding an accident which I, or my covered dependents, are injured as a result of the acts of a third party. I will do whatever is reasonable needed to secure the carrier's rights and shall do nothing to damage such rights I will abide by this agreement, only if my health insurance policy contains language that gives the carrier subrogation and rights of reimbursement.

Authorization for Payment of Insurance Benefits to Provider
I authorize payment of the medical benefits, otherwise payable to me, to be made payable and mailed directly to Life Line Chiropractic for professional serviced rendered. No other third party, including attorney, should receive payment of my bill except this office for the remainder of

this claim, unless denoted by a LOP for the attorney. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage, and will send payments directly to this office. If payment is not rendered within 90 days upon receipt of payment from any other sources, then your account will be considered in default. Defaulted accounts are turned over to a collection agency and/or attorney for nonpayment. All charges incurred will be added to your bill along with any postage, interest or filing fees.

Returned Check Fee- I understand that the fee for any returned check for insufficient funds, closed accounts or any other ancillary concerns will be an additional $45.00 charge. This fee will be required to be paid by credit card, money order, or cash.

Social Security # - All patients are requested to provide their social security number; for insurance purpose primarily and/or collections

Missed Appointment- I understand that it is my responsibility to keep all my appointments for my treatment. In the event that I must cancel my appointment, I will give 24hours notice. If I do not give 24 hours notice my account may be subjected to a $25.00 cancellation fee. I as a new patient missing the appointment without 24hrs notice may be charged a $50 cancellation fee and or not seen in the future for treatment.

Self Pay - Self pay patients are required to pay for visits in full at the time of service unless other financial arrangements have been made both verbally and written

Worker's Compensation Cases- If you are here as a result of work related injury, we will require information regarding both health insurance and workers compensation insurance. We will do all that we can to file your claim accurately to get financial compensation for your care. However, if payment is not received, the balance is your responsibility

Account Balances- I understand that it is a privilege to have LLC file my insurance but insurance benefits are not a guarantee of payment. I fully understand that any unpaid balances past 90 days can be subjected to a 9.99% interest fee and subject to a 40% collection fee along and sent to a collection company for further assistance with restitution your account. Any balance over $300.00 will be halted in treatment till at least 50% of the balance is paid off. Then treatment shall be re-instated.

Credit Card Processing Fee – LLC charges a $3.00 processing fee

Administrative Fee – LLC charges a $30.00 annual admin fee to cover costs of services that may not be covered by your insurance and or treatment costs.

Crossover Insurance-If LLC has to submit documents on your behalf to your insurance company to ensure proper payment and reicept of your claims via fax and/or mailing there will be a separate fee. Copy fee of .50 up to the first 30 pages then .65 for each additional as well as postage (pricing to be determined at the time) and clerical fee of $15.00

Billing- For questions or concerns about your bill feel free to contact our office and we will direct your questions to the appropriate person/ persons

Medical Referrals- Referrals to other physician's offices are a courtesy to our patients. We will send over the necessary documentation to start the process; however we do not make the appointments nor do we confirm your insurance acceptance to that physician's group.

Medical Records- You may request a copy of your medical records with at least 48 hours advance notice. There may be a charge of $15 per clerical and standard copy fees (pages 1-30 @ .65 cents and 31- up @. 50 cents)

Personal Injury Patients- I understand that LLC will communicate and submit claims to my attorney and/or insurance company to settle my account but ultimately I am the responsible person or any remaining balance. There is no guarantee of payment by the attorney and/or the insurance company. I am required to pay 100% of the office contracted rate for each service at the time of service unless prior arrangements have been made.

Vacationers- I understand that LLC will communicate and submit claims to my insurance company to settle my account but ultimately the responsible party is myself for any remaining balance on the account. I understand that I may be required to pay LLC standard office visit fee, which will be deducted from my balance at the end of treatment, unless prior arrangements have been made.

I have reviewed and fully understand and accept the terms of this consent. I give my verbal acceptance

You have the right to revoke parts of this authorization in writing at any time.

Sign_____