

South Boulder Chiropractic

Mary G. Elsea, D.C. • Elizabeth Decker, D.C. • Christopher Rowenhorst, D.C. • Hillary Bauman, D.C.
4150 Darley Ave, Suite 6 • Boulder, CO 80305 • Ph: 303-499-5000 • Fax: 303-499-4962

FINANCIAL POLICY

WELCOME TO OUR OFFICE! Our goal is to provide you with the best possible chiropractic care, and to have it be a pleasant, positive experience for all of us. In order to serve you more effectively, we have established a few policies.

APPOINTMENTS: Your appointments are times reserved and committed exclusively for you. We realize that emergencies do occur, and appointments must sometimes be changed. Charges may be made for missed appointments and appointments cancelled without 24 hours advance notice.

PAYMENTS: Payment is due at the time services are rendered, unless other arrangements have been made in advance. We accept cash, check, or VISA/MC. Returned checks are subject to a \$25 service charge. Any account that becomes delinquent will be subject to collections service. Payment of court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon at 18% per annum on all such amounts outstanding, will be your responsibility.

INSURANCE: As a service to our patients, we do accept assignment of insurance benefits on most policies. In addition, we are participating providers with certain managed care organizations. You must sign the authorization form for the insurance or managed care company to pay our office directly for services rendered, and you are responsible for payment of your portion or copay at the time of service. If your deductible has not been met, you are responsible for full payment until it has been met; then only your portion thereafter. In order to bill your insurance, we must be notified immediately of insurance coverage or changes, as well as a copy of your card and insured's information.

NOTE: We are happy to assist you in verifying chiropractic benefits of your particular policy. All insurance companies begin verification with a pre-recorded message which states: "This verification of benefits is not a guarantee of payment. This is a simple overview of the policy. Only when a claim is received can it be reviewed for medical necessity and for policy provisions. Again, this is not a guarantee of payment."

1. **DEDUCTIBLE:** the amount for which the insured patient is liable for before an insurance company will begin paying for benefits.
2. **MANAGED CARE ORGANIZATIONS:** include PPO, HMO, EPO, POS. Policies will vary. **IN-NETWORK:** some insurance policies require you to go to certain providers (referred to as in-network doctors). **OUT-OF-NETWORK:** if your insurance policy requires you to go to certain providers and you choose to go to a provider who is not within that group, there may be a different deductible and/or different benefits. Moreover, most insurance policies will not pay for ANY care out-of-network.
3. Your insurance policy is a contract between you and your insurance company. You are ultimately responsible for any unpaid balance on your account, unless we are part of a PPO which stipulates otherwise.
4. Some services may not be a covered benefit in all policies. Some insurance companies arbitrarily select certain services they will not cover. You will be fully responsible for any/all services rendered that the doctor deems necessary for your care, but is not a covered benefit in your policy.
5. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This only applies to companies who pay a percentage (such as or 80%) or "UCR." "U.C.R." is defined as "Usual Customary and Reasonable" by most companies. This statement does NOT apply to companies who reimburse on an arbitrary "schedule of fees", which bears no relationship to the current standard and cost of care in this area.

I have read and understand the above information.

Signature

Date

South Boulder Chiropractic

Mary G. Elsea, D.C. • Elizabeth Decker, D.C. • Christopher Rowenhorst, D.C. • Hillary Bauman, D.C.
4150 Darley Ave, Suite 6 • Boulder, CO 80305 • Ph: 303-499-5000 • Fax: 303-499-4962

Patient name _____ Birthdate ____/____/____ Age _____

Address _____ City _____ State _____ Zip _____

Home phone: _____ Work phone: _____

Sex ____M ____F Please Circle One: **Single** **Married** **Divorced** **Other**

Occupation _____ Employer _____

Spouse's name _____ Employer _____ Work Phone _____

Physician _____ Office _____ Phone _____

Whom may we contact in the case of emergency? _____ Phone _____

If under 18, parent/legal guardian's name: _____

Whom may we thank for referring you to us? _____

INSURANCE Company: _____ OR CASH Patient

Who is the primary insured? _____ Insured's Date of Birth _____

Insured's Home Address (if different from yours) _____

Relationship of insured to patient _____

We must emphasize that as chiropractic providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account from the day charges are incurred for professional services rendered. I understand that a 2% service charge (or a \$5.00 minimum, whichever is greater) may be added to all accounts over 30 days past due. We realize that temporary financial problems may affect the timely payment of your account. If such problems do arise, please contact us promptly for assistance in the management of your account.

I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you IMMEDIATELY of any changes in my health status or the above information.

I understand that the above named doctors may cover for on another in the event of illness, vacation, or in the case of scheduling difficulties.

If you have any questions about the above information, PLEASE DO NOT HESITATE TO ASK.

Responsible party (or guardian) signature _____ Date _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize the office of Dr. Mary Elsea, Dr. Elizabeth Decker, Dr. Christopher Rowenhorst and Dr. Hillary Bauman to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

SIGNED: _____ Witnessed: _____ Date: _____