



LAST NAME: _____

FIRST NAME: _____

POLICY ON PATIENT ACCOUNTS AND CONDITIONS OF TREATMENT

Elements of Health & Wellness, Inc. (DBA Adventure Chiropractic) is a private institution that operates for the benefit of people who seek the services of our medical staff. We provide quality care at what we believe to be a fair and reasonable fee. Since we do not receive financial assistance from any outside source we must recover the cost of providing services for our patients. It is Adventure Chiropractic's policy that the responsibility for pre-authorization on paying for care will be placed upon those who receive it; therefore, all accounts will be administered under the following guidelines:

1. **Missed Appointment(s):** If you are unable to keep a scheduled appointment we require sufficient time (24 hours) in order to fill that time slot. If you **NO SHOW** or do not call in advance you may be charged **\$25**. This is at the discretion of Adventure Chiropractic.
2. **First Time Patient:** Any first time patient at this office will be required to pay charges for the visit *if their insurance deductible has not been met OR the visit is not covered by their health insurance*. The obligation to pay for medical services may not be deferred for any reason. If the account is referred to any agency for collections the patient will be responsible for all expenses.
3. **Cost of Service(s):** The cost of service(s) rendered varies based on what was performed. A "Time of Service" discount is offered to anyone who pays when the service(s) were performed. However, if payment is not made at the time of service, you will be responsible for the full amount. Massage therapy charges range from \$30 - \$160 depending on the length of the massage and time of payment. Some Chiropractic charges are: New patient exam: \$45-140+, Existing patient exam: \$25-95+, typical/average visit: \$45 -109+. For specific charges to your account please ask Dr. Keys or the receptionist.
4. **Account Balance:** If you have a balance on your account you will receive a monthly statement until the account is paid in full. Bills are due and payable upon receipt of this statement. We will bill your insurance carrier as a courtesy for you. Your insurance should make payments directly to this office and you will be responsible for any deductibles, co-payments, and/or other patient balances. This service does not guarantee payment for your treatment. You have an arrangement with your insurance carrier to pay for services rendered. You or the responsible party is ultimately responsible for all charges incurred.
5. **Payment Options:** Payment options include cash, check, visa, mastercard, money order, travelers check, or certified check. If you have special financial needs please feel free to discuss this with us and establish an extension of credit terms. Interest accrues on charges not paid after 30 days of the first bill at a rate of 1.5% per month (18% per year) until paid in full (ORS 30.701).
6. **Medicare:** Adventure Chiropractic is a participating provider with Medicare. Medicare will reimburse at 80% of what they allow minus an annual deductible of \$135.00 (as of 1/1/09). Supplemental insurance plans usually cover 20% and follow Medicare's guidelines for payment. **Medicare currently only pays for a Chiropractic adjustment.** Medicare does not cover the initial exam, follow-up exams or any adjunctive procedures such as x-ray, massage, therapeutic exercises, electric modalities, etc. **The patient or responsible party is liable for any such charges if applicable.** By signing this form it authorizes any holder of medical or other information regarding the patient named above to release such information to the Social Security Administration, its intermediate or carrier effective from this date.
7. **Authorization for disclosure of information for purpose of service reimbursement:** I hereby authorize Adventure Chiropractic to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient's medical charges. Disclosure of medical records may be necessary to determine eligibility for liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing except to the extent that Adventure Chiropractic has already taken action on my claim.
8. **Services:** Some of the services or supplies this office might suggest may be considered non-covered items under you plan; consequently, you will be held responsible for these services and/or supplies at the time of service.

Date: _____

PATIENT/RESPONSIBLE PARTY: _____