

**SCHUBBE RESCH CHIROPRACTIC AND PHYSICAL THERAPY CENTER
FINANCIAL POLICY**

We strive to exceed expectation and eliminate financial surprises for all of our patients. We want to partner with you in keeping your account accurate and up-to-date. Your patient financial rights and responsibilities are listed below. Please review and sign this document. The original document will be placed in your patient record and a copy given to you for your records by request. This document is good for the calendar year of the date of signing. Thank you.

I understand that I am responsible for all charges including but not limited to: denied claims, deductibles & co-insurance amounts. I understand I will be responsible for the full charged amount if I do not provide Schubbe Resch Chiropractic and PT Center with my insurance information. I further understand Schubbe Resch will honor all discounts, fee schedules, and network participation pricing as per signed contract. Discounts assigned by organizations or insurances without a signed agreement with Schubbe Resch Chiropractic and PT Center will become the patient's responsibility.

Supplies and all over the counter items must be paid for at the time of service. There are no refunds or guarantees on any supplies or medical equipment.

I understand that if my health insurance does not include coverage for chiropractic and/or physical therapy benefits, I will be required to pay at the time of services. I further understand that I have the right to establish a payment plan when costs exceed my ability to pay. Payment Plan Contracts are available at the front office.

As a courtesy to our patients, Schubbe Resch will contact your insurance carrier for coverage information. However, due to HIPAA laws, benefit information may be limited. I understand it is my responsibility to verify specific benefit information with my insurance carrier as well.

I understand that Schubbe Resch does not bill secondary insurance, or submit charges directly to a Flexible Spending Account. If you allow us to copy your secondary insurance card, we will provide you with account information generally required by most secondary insurances or flexible account managers.

I understand that I need to cancel a Physical Therapy appointment 24 hours prior to the scheduled appointment time. A **\$50 NO SHOW CHARGE** will be applied to my account if I do not call & cancel my scheduled physical therapy appointment. I understand this charge is not covered by insurance and will be my responsibility. Most therapy appointments are scheduled for one-on-one treatment with a therapist for 45 minutes in duration.

Attention Medicare Patients: Schubbe Resch Chiropractic accepts Medicare Assignment for Chiropractic adjustments. I understand that Medicare does not cover x-rays, exams, therapies, or supplies. Schubbe Resch will submit my claims to Medicare first, then to secondary or supplemental insurance carriers on my behalf.

Patient signature _____ **Date** _____

Parent or Guardian _____ **Date** _____

Relationship to Patient _____

Revised 9-5-08