

Robeson Family Chiropractic Inc.
FINANCIAL AGREEMENT

Our recommendations are based on a desire to see you get well and stay well. We ask that you read, initial and understand our policy as it applies to your particular situation (A-E).

A)Health Insurance (NON MEDICARE)

Robeson Family Chiropractic, Inc. will attempt to verify your insurance coverage before your first adjustment or Chiropractic service. **Robeson Family Chiropractic Inc.** will inform you either in writing or verbally the amount your insurance company will cover. *The insurance company does not guarantee payment. Robeson Family Chiropractic Inc.* will make every attempt (including asking you to contact the insurance company, if needed) to obtain payment on your behalf. *If your insurance claim is not paid or if the insurance company sends the payment to you, you will personally be responsible for any balances on your account. Co-payments and payments toward the deductible are due at the time of service.* If we are a “in network” or “preferred provider” with your carrier we must follow the terms of our contractual agreement and charge the contracted rate . If we are out of network you may choose to accept our Time of Service fees and policy.

_____(initials)

B)Medicaid

Medicaid will pay for 8 Chiropractic adjustments per Medicaid Calendar year only. They will also pay for spinal x-rays (if needed). Medicaid will only pay for spinal pain and usually does not cover children. Furthermore, the services listed below are not covered.

Cost Of Non-Covered Services

Examinations \$55 (99201-4)

Physiotherapies (Electrical Muscle Stimulation(97014) , Traction(97012), , Cold Laser (97026), Manual Therapy(97140), , Exercise Therapy(97110)\$15 Aqua Massage \$ 20 (\$1 a min.)

_____(initials)

C)Medicare

Medicare Does Cover Chiropractic Care - But With Limitations.

Medicare will pay for spinal manipulation (adjustments of the spine) only!

Any X-rays (if needed) therapies, supports, supplements, examinations, and etc. offered in this office are not covered. Since Medicare does not cover these services, most secondary insurances do not cover them either! Medicare typically covers 80% of the spinal adjustments. All other services are the patient’s responsibility and are due at the time of service unless you have a secondary insurance.

These adjustments, are limited to medical necessity as deemed by Medicare. The number of treatments allowed depends on the condition being treated. Medicare also does not pay for “Chiropractic Maintenance”, which it feels is not medically necessary. Your condition may require more manipulations than allowed by Medicare .We will inform you if we think they will not pay for your spinal manipulation treatments and have you sign an advance beneficiary notice. We can only charge you the current allowable fee set by Medicare for a spinal adjustment.

Cost Of Non-Covered Services

Examinations \$55 (99201-4)

X-rays per view \$30 (note 2 view minimum=\$60)

Physiotherapies (Electrical Muscle Stimulation(97014) , Traction(97012), , Cold Laser (97026), Manual Therapy(97140), , Exercise Therapy(97110)\$15 Aqua Massage \$ 20 (\$1 a min.)

_____(initials)

D)TIME OF SERVICE “TOS“ (No Health Insurance or if you choose to file yourself)

Because of the high cost of processing health insurance claims, we can offer a lower cost of care . We can do this only if payment is made in full at the time of service, we are out of network, or your “In Network” insurance allows us to charge a TOS discount. We can only do this if we do not have to process your claim and wait on payment from a third party. When this option is chosen we will gladly assist you in processing your own insurance claims. but we will not be able to file them for you if you decide to apply for reimbursement. We can not generate a claim, support medical necessity, or write any reports. We can only give you a receipt, “super bill“,. If you choose to use your insurance you may opt out of the time of service fees and we will bill your insurance . *We can not offer this reduced rate if you do not pay at the time of service.*

Time of Service Fees Per Visit

Evaluation and Exam \$55(99201-4)

Adjustment (98940-2) \$38

Spinal check for children under 12 (99201/99211)\$15

X-ray per view \$30

Physiotherapies \$15 Electrical muscle Stimulation(97014), Traction (97012), Cold Laser,(97026), Manual Therapy(97140), Exercise Therapy(97110)\$15

Aqua Massage \$ 20(\$1 a min.)

Maintenance or Corrective Care Time of Service Plans

Pre-Pay for future visits as recommended by Dr. Robeson and SAVE MONEY.

If Dr. Robeson recommended a specific treatment plan or maintenance plan and you wish to purchase visits in advance you can save more money

	Adjustments Only(98940-2)	Adjustments and Therapies *
6 Visits	\$216 (approx. \$36 per visit)	\$302(approx. \$50 per visit)
12 Visits	\$410(approx. \$34 per visit)	\$573(approx. \$47 per visit)
24 Visits	\$775(approx. \$32 per visit)	\$1081(approx. \$45 per visit)
36 Visits	\$1094(approx. \$30 per visit)	\$1528(approx. \$42 per visit)
48 Visits	\$1368(approx. \$28.50 per visit)	\$1908(approx. \$39 per visit)

_____(initials)

*(does not include AquaMassage) (\$1 a min.)

E)AUTOMOBILE INJURY OR PERSONAL INJURY PAYMENTS

Please present your automobile insurance card, the accident report and your health insurance card. You can choose (1) to pay cash and **Robeson Family Chiropractic** will provide you with a statement of your charges for reimbursement. (2) Accept assignment and **Robeson Family Chiropractic** will bill your auto and/or health insurance on your behalf. *If your insurance claim is not paid or if the insurance company sends the payment to you, you will personally be responsible for any balances on your account.*

Option 1 _____(initials) Option 2 _____(initials)

In the event a check is returned once for non-sufficient funds, a charge of \$30.00 will be added to your account and will be due at the time of the next visit to Robeson Family Chiropractic. On the second occurrence of non-sufficient funds, you will be asked to make remaining payments by cash, credit card or money order I have read the financial policy as it applies to me (A-D). I have indicated my understanding by my initials above for the appropriate and applicable choices and my signature below.

Patients Signature
08/19/2009

Date