Financial Policies: Understanding Our Affordable Evaluation and Treatment Payment Options

AGREEMENT TO PAY FOR TREATMENT

I understand that I am responsible for payment at the time of service. Payment is due at the time of service even if a claim is submitted on your behalf to your insurance carrier for reimbursement. I understand that if payment is made by someone not present with the patient when they are in office, credit card information, check, or cash should be available to staff during checkout. Billing statements can be sent by fax, post, or emailed to the payer with duplicates to the patient when the patient leaves the office. Whenever helpful to the patient, financial planning quotes for services anticipated can be provided in advance of your appointment although unanticipated decreases or increases on rare occasions may occur.

I, the responsible party, hereby agree to pay all charges submitted by this office during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor. I further understand that if I am not present for an appointment or do not give 24 business hours’ notice for routine follow up appointments when canceling an appointment I may be responsible for a $150 cancelation fee and for charges up to the potential cost of the visit. For first time appointments 48 business hours’ notice is required or the deposit will be retained and non-transferable.

AFFORDABLE PAYMENT OPTIONS

At times, financial burdens related to the cost of the essential evaluation & treatment may discourage patients from pursuing appropriate evaluations and necessary treatments.

To minimize such inconveniences, we have put some options as an additional resource for your consideration in overcoming any financing obstacles.

1. CareCredit Financing

OUTSTANDING BALANCES

Delinquent accounts over 60 days will be sent to collections for processing.
At which point all collection fees, contingent or not, shall be added to the patient’s responsibility.
In the event legal action is required, the patient shall be responsible for all reasonable attorney’s fees and costs.

**All Delinquent accounts shall be assessed a 15% late fee per month until satisfied**

Medication refills will be discontinued for all patients or family members with outstanding accounts.
If your check is returned due to non-sufficient funds you will be charged an additional $35.

It is your responsibility to notify our office if there is a change in your coverage, residence, phone number, email or pharmacy location and contact information. Due to time constraints and the substantial volume of prescription refills each day this office will unfortunately disregard any prescriptions without proper and/or updated pharmacy information. It is the patient’s responsibility to provide where your prescriptions are to be sent.
**IT IS YOUR RESPONSIBILITY TO CHECK YOUR OUT-OF-NETWORK INSURANCE BENEFITS**

Some insurance carriers may allow reimbursements for some or all of the services provided if deemed medically necessary. However, the agreement of the insurance company to pay for medical care is between you and your carrier.

It is your responsibility to determine your out-of-network deductibles (the amount you must pay before the carrier makes any sort of payment); reimbursement for a service may be dependent upon a deductible which is between you and your insurance carrier.

If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. As a courtesy, we will prepare and submit a claim to your insurance company for potential reimbursement within 7-14 days of your appointment with Dr. Duane.

**FEES FOR DOCUMENTATION**

Often our patients require comprehensive documentation. Your initial comprehensive evaluation includes any documentation you may need for a period of 12 months to family members, other providers, and educational entities. **After 12 months requests may be subject to a document processing fee**

**Documents provided to legal entities will be subject to a document processing fee**

I have read and I understand the above financial policies and I agree to abide by all terms.

Signed: ____________________________  Date: ____________________________
ADVANCED BENEFICIARY NOTICE (ABN) for Private Insurance

NOTE: You need to make a choice about receiving treatment today.

We expect that your health insurance carrier / third party payer will reimburse for the treatment(s)/services provided today, but there is a possibility that they may not. The health insurance carrier does not pay for all of your health care costs. Your health insurance carrier only pays for covered items and services when their rules are met. The fact that your insurance provider may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these treatments/services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

Help is available should your insurance carrier require additional information to determine benefits. Please notify our office if you require assistance. We will need you to provide a copy of the explanation of benefits (EOB). If insurance reimbursement checks are sent to us in error, they will be returned to you promptly.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

Option 1: YES. I want to receive the treatment(s)/services.
I am aware that Dr. Duane is not contracted with any insurance carriers and therefore does not ascribe to their fee schedules (with the exception of Medicare). That is, the services provided will be billed above the allowable billing rate determined by your insurance carrier. I understand my health insurance carrier will not decide whether to pay unless I receive the treatment(s) and/or services. Please provide me with the insurance claim form for submittal to the health insurance carrier. I understand that you may bill me for the treatment(s) and/or services, and that I may have to pay the bill while my health insurance carrier is making its decision. If the health insurance carrier does pay, you will refund to me any payments I made to you that are due to me. If my health insurance carrier denies payments, I agree to be personally and fully responsible for the payment. That is, I will pay personally either out of pocket or through any other insurance that I may have. I understand that I can appeal my health insurance carrier’s decision.

Option 2: No. I have decided not to receive the treatment(s)/services.
I will not receive the treatment(s)/services. I understand that you will not be able to submit a claim to my health insurance carrier and that I will not be able to appeal your opinion that my insurance may not pay.

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to my health insurance carrier, your health information on this form may be shared with the third party payer. Your health insurance carrier will keep your health information that they receive confidential.

Patient’s Name:  
(Please Print)  
Signed:  
Date:
ADVANCE BENEFICIARY NOTICE (ABN) for Medicare

NOTE: You need to make a choice about receiving these health care items or services. We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. The following items/services are previously known not to be covered by Medicare:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>96116</td>
<td>Psychological Tests</td>
</tr>
<tr>
<td>96101</td>
<td></td>
</tr>
<tr>
<td>97750</td>
<td>Physical performance tests</td>
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<tr>
<td>EMG's</td>
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<tr>
<td>92499</td>
<td>Pupilometer</td>
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<td>92585</td>
<td>BAEP</td>
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<tr>
<td>92585</td>
<td>N100/P300</td>
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<tr>
<td>95281/52</td>
<td>MOTUS</td>
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<tr>
<td>36415</td>
<td>Venipuncture</td>
</tr>
<tr>
<td>20550</td>
<td>Trigger point infiltration</td>
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The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don’t understand why Medicare probably won’t pay.
- Ask us how much these items or services will cost you (Estimated Cost: $___________), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

Option 1. YES. I want to receive these items or services.
I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me.

Option 2. NO.
I have decided not to receive these items or services. I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won’t pay.

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

Patient’s Name: (Please Print)
Signed:
Medicare # (HICN):
Date:

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