



701 E. North St., Ste. B • Elburn, IL 60119 • Phone: (630) 365-5820 • Fax: (630) 365-5815

## FINANCIAL POLICY

**Insurance Company:** \_\_\_\_\_ **ID#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Patient Date of Birth:** \_\_\_\_\_  
Last Legal First Middle Initial

**Name of Insured:** \_\_\_\_\_ **Insured Date of Birth:** \_\_\_\_\_  
(if different from patient) Last Legal First Middle Initial

→ If you would like our office to bill your insurance, please provide your credit card information below.  
Your card will be kept on file but not charged without prior notification.  
Without a card on file, payment is due in full at the time services are rendered.

**CREDIT CARD #:** \_\_\_\_\_ **CVC:** \_\_\_\_\_ **EXPIRATION DATE:** \_\_\_\_\_

**CARDHOLDER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

→ Please *initial* the billing option below that you agree to follow:

\_\_\_\_\_ **Private Pay:** I will pay for all services, as they are rendered, and submit my own insurance claims.

\_\_\_\_\_ **PPO/Preferred Provider Organization:** You are in my PPO network. I am responsible for any co-payment, deductible, and non-covered services, according to my plan. I will pay the co-payment, deductible, and non-covered services that I am responsible for, as laid out by my plan.

\_\_\_\_\_ **Group/Health:** I will pay the co-payment, deductible, and non-covered services that I am responsible for, as laid out by my plan. I understand that if my insurance company does not pay the balance within 60 days of submission, I am responsible for the entire balance overdue.

\_\_\_\_\_ **HMO/POS:** My primary care physician (PCP) has agreed to authorize a referral to your office. It is my responsibility to make sure that the number of visits authorized remain current. I understand that I am responsible for, and will pay, whatever co-payment and non-covered services that my plan sets forth.

\_\_\_\_\_ **Medicare:** I am a Medicare participant and I understand that Medicare only pays for spinal manipulation procedures at 80% of their approved amount, and only after my yearly deductible has been met. Your office will bill Medicare directly. Medicare should then reimburse your office at 80% of the spinal manipulation fee. Any supplemental policy should also reimburse your office, according to the benefits allowed by that policy. If I have a supplemental policy, it may cover the 20% of the portion of the spinal manipulation fee not paid by Medicare, and/or some percentage of any other procedures (besides spinal manipulation) not covered by Medicare. Regardless of my insurance coverage, I understand that I am ultimately personally responsible for the balance of all charges for all services rendered and supplies purchased.

\_\_\_\_\_ **Worker's Compensation:** I was involved in an injury at work. I will see to it that all appropriate paper work is filed by my employer (i.e. accident report, etc.). I understand that it is my right to have any bills incurred as a result of a work-related accident paid for. If after 60 days my claim is not paid, I will personally pay the overdue balance. I understand that if this is the case, my rights may have been violated and I have the option to seek legal counsel.

\_\_\_\_\_ **Auto Accident/Personal Injury:** I was involved in an automobile accident/personal injury and would like to have you submit all charges to my insurance company for me. I will sign all liens necessary to protect your office. If the first insurance payment is not received within 45 days of my first date of service, I agree to pay \$100.00 per month while your office awaits final payment. I will be promptly reimbursed should any overpayment occur on my account. I understand that regardless of payment arrangements, I am personally responsible for the entire balance within 90 days of completion of treatment.

*I agree to provide at least 24-hours notice if I need to cancel or reschedule any appointment. I agree to pay a \$40.00 missed appointment fee for each appointment for which I fail to provide appropriate notice.*

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



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**AUTHORIZATION (to release information & settle insurance appeals or disputes)**

I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

**SIGNATURE OF PATIENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SIGNATURE OF INSURED (If Different):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ASSIGNMENT (of benefits to doctor)**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Trillium Health & Wellness, S.C. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

**SIGNATURE OF PATIENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SIGNATURE OF INSURED (If Different):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES (HIPAA)**

I, \_\_\_\_\_, hereby acknowledge the physician's Notice of Privacy Practices.

*Patient's Name*

The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

**SIGNATURE OF PATIENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_