Policy of Payment

☐ I understand that the Estimated Out of Pocket Expenses are due prior to receiving any services and that the benefits quoted are not a guarantee of payment. Insurance disclaimer: *A quote of benefits does not guarantee payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's health insurance plan at the time of service.*

☐ Any refunds owed to our patients will be refunded after your insurance Explanation of Benefits (EOB) has been received and verified by our Billing Manager and the Accountant. We will make every effort to issue refund checks within 180 days from the date the EOB was received and verified. This should allow sufficient time for primary and any secondary insurance payers to process claims for payment. For incomplete exams, refunds will be processed after your insurance Explanation of Benefits (EOB) has been received and verified by our Billing Manager and the Accountant. For self-pay patients, an amount of $125 will be processed per exam.

☐ If your EOB determines the allowed amount is more than the amount collected at the time of service, you may receive a bill for additional patient responsibility. Upon receipt of your insurance companies' explanation of payment, a statement will be billed to the email address provided at the time of service. Payment is due within 30 days of the statement issued date. Any unpaid balances remaining after 90 days may be referred to an outside collections agency for recovery. At that time, you will be fully responsible for any collection fees and court costs. Thank you for your patience and understanding.

By initialing above, you acknowledge that you have received this notice and understand this policy.

Accident/Injury Questionnaire

Are you receiving treatment or are you coming in today for an injury/illness where another party is liable or could be covered under Workers Compensation benefits or a no-fault auto insurance? *Circle One* ☐ YES ☐ NO

Please provide details about the reason for your visit:

Patient Name: _____ Date of Birth: ___/___/___ SSN: ___-___-___

Subscriber: _____ Policy #: _____ Group #: _____

Date of Injury: ___/___/___

Where did the injury occur? _____

What activity were you doing when the injury occurred? _____

Please explain what happened: _____

_____

_____

_____

Workers Comp./Auto Insurance Carrier: _____ Policy/Claim #: _____

Attorney (if applicable): _____ Contact Phone #: ___-___-___

Patient Signature: _____ **Date:** ___/___/___