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LAKESHORE FAMILY CHIROPRACTIC HEALTH & WELLNESS

WELCOME TO LAKESHORE FAMILY CHIROPRACTIC HEALTH & WELLNESS

We are excited to take care of all your health care needs, but first, it is important that you know our current office policies (effective 08/15/10). If you are a returning patient, be advised, some of these policies may have changed since your last visit. Please don't hesitate to ask us if you have any questions.

PLEASE READ AND INITIAL AFTER EACH SECTION:

BILLING INSURANCE

Lakeshore Family Chiropractic Health & Wellness is a preferred provider for many, but not all insurance companies. As a courtesy, we will bill your *primary insurance*. Please present a current insurance card or proof of insurance with ID. Although we try to verify your coverage's for services, *we cannot guarantee that your insurance will pay*. We are not insurance agents. We can only estimate your portion of the bill at time of service. If your insurance company denies your claim, or pays less than expected, you will be billed for the balance. *You are responsible for all charges incurred at Lakeshore Family Chiropractic Health & Wellness regardless of insurance coverage.*

Initials:_____

PAST DUE ACCOUNTS

Your estimated portion of the bill is due at the time of service. If you have insurance, we will do our best to estimate your portion; however, you may receive a statement after insurance has been processed. In efforts to keep our health care costs down, we ask that you pay promptly. Accounts over 30 days past due will incur finance fees of 10% per month until balance is paid off. Accounts over 120 days will be sent to a collection agency and may accrue addition fees. To avoid this, payment plans may be arranged and we accept most major credit cards.

Initials:_____

HIPAA

In accordance with Health Insurance Portability & Accountability Act (HIPAA), Lakeshore Family Chiropractic Health & Wellness will treat your medical records and personal information with the most respect and privacy. Please see our Notice of Privacy Practices; you may request a copy for your records at any time.

Initials:_____

RED FLAG RULE

In accordance with the Federal Trade Commission, we must see a current driver's license / ID card to verify identity (patients over 18). This is mandatory for any patients who want their insurance billed. This is an effort to reduce credit card fraud, insurance fraud, and identify theft issues. Patients refusing to provide ID must pay cost at the time of service.

Initials:_____

SIGNATURE ON FILE

Your personal and medical health information will be used to provide quality chiropractic care; including diagnosis, and treatment and proper referrals when appropriate. This information may also be used by Lakeshore Family Chiropractic Health & Wellness to bill insurance, collect payments, and make medical referrals as needed.

Initials:_____

TRANSFER OF RECORDS

You must sign an official *release of records* if you wish for any of your information (medical or personal) to be shared with anyone outside of Lakeshore Family Chiropractic Health & Wellness. Likewise, if you would like us to assist in getting copies of your records from past doctors, please ask the receptionist for a *request of records* form that makes it easy.

Initials:_____

MISSED APPOINTMENTS

We understand that uncontrolled circumstances and emergencies happen. We do not have a missed or canceled appointment fee. We just request that you give us a call so we can fill your adjustment if another Practice Member requests it.

Initials:_____

PLEASE READ, SIGN & DATE BELOW

In signing below, I state that I understand and accept Lakeshore Family Chiropractic Health & Wellness' Policies. In addition, I authorize Lakeshore Family Chiropractic Health & Wellness to release any information required to process insurance claims and authorize insurance payment to be paid directly to Lakeshore Family Chiropractic Health & Wellness. I understand that my insurance company may pay less than the actual bill for services. I the Patient/Responsible Party, accept financial responsibility for all charges incurred regardless of insurance coverage.

PRINT Patient's Name: _____

PRINT Name of Responsible Party (if not Patient): _____

SIGNATURE of Patient/Responsible Party: _____

Date: _____

LAKESHORE FAMILY CHIROPRACTIC HEALTH & WELLNESS

LIVE HEALTHY
LIVE NATURAL
LIVE HAPPY