

Insurance Assignment Policy

As a courtesy, we accept insurance on assignment, upon verification of your benefits and coverage. We gladly file all claims for service, according to our policies, directly to your insurance carrier.

- You will be responsible for any/all deductibles, co-insurance/ payments, and non-covered benefits. We will gladly provide several options to help you take care of these out of pocket expenses.
- We will do our best to accurately file your claims; however, we cannot be responsible for how your insurance company chooses to reimburse us for your care, even if it is different than the benefits they quoted to us.
- Should your carrier deny any claims for service, we will provide the necessary documents for a valid appeal or reconsideration. However, if this endeavor is not successful, it will be your responsibility to take an active role in the authorization process and stay updated on their dates of expiration. We will not assume the responsibility for any unauthorized treatment; your involvement always ensures a better chance of obtaining full coverage.
- If your care requires any authorization from your Primary Health Care Physician or Insurance carrier, we will do our best to maintain these authorizations for treatment. However, it is your responsibility to take an active role in the authorization process, and stay updated on their dates of expiration. We will not assume the responsibility for any unauthorized treatment; your involvement always ensures a better chance of obtaining full coverage.
- Although insurance coverage varies depending on individual contracts and plans, we find that most plans do not provide coverage or benefits for the following:
 1. Rehabilitative, Maintenance, or chiropractic wellness care
 2. Supports, brace, cervical pillows, and most supplies
 3. Supplements

Based on the high number of insurance plans that do not cover the services listed above, we have had to add the following terms to our assignment policy. If any of the above listed services or supplies are rendered, they are required to be paid up front, at the time of services, and will not be taken on insurance assignment. Upon payment of said services, and we will gladly submit all services rendered, but should your insurance company deem them a non-covered benefit, and deny payment, you will be responsible for full, unpaid amount of submitted services.

AGREEMENT

With my signature below, I confirm that I have been informed of and understand the terms and policies as outlined above, I agree to be responsible for payment and insurance processing for any non-covered service listed above, and to make payment arrangements for my estimated financial responsibility. My signature will also allow for the release of medical records to my insurance company for the purpose of processing claims.

PATIENT'S NAME _____ BIRTH DATE _____

SIGNATURE _____ DATE _____