

Spring Spine Center
6225 FM 2920, Suite 200
Spring, Texas 77379
(281) 376-1288 Fax (281) 378-4706

This form must be read and signed in order to see the doctor.

Financial Policies

Our purpose is to provide the very best chiropractic care possible. One of the ways we accomplish this is to eliminate potential problems that may detract from the quality of our work. Therefore, we have developed the following financial policies:

We will verify your insurance coverage and review your benefits with you. It is your responsibility to keep up with any maximum limitations that your policy imposes. Keep in mind that verification of benefits is not a guarantee that your insurance company will pay for all services rendered. You may request a copy of your verification page at any time.

As a service to our patients, we will bill your insurance company for your treatments. Any unpaid balance that your insurance company has not paid will become your responsibility. Unless otherwise stipulated, the insurance contract is between the patient and the insurance carrier, not between the doctor and the insurance company.

All co-payments **MUST** be paid at the time services are rendered. Should any patient wish to make monthly payment arrangements, please see the office manager for additional information.

A current copy of the patients' insurance card is required in order to file claims. All services received prior to insurance verification must be paid in full at the time services are rendered. When the dates of service in question are paid in full by your insurance carrier, all over-payments will then be credited to the patients account.

Should your insurance carrier change during the course of treatments or between visits, it is patients' responsibility to update their insurance information with the billing department.

Initial _____

Referrals

It is the patient's responsibility to obtain referrals when necessary from their primary care provider prior to treatment.

I agree to pay in full for all services rendered without the required referral.

Initial _____

Claims for Personal Injury

We will file personal injury claims to your auto insurance carrier via your PIP policy for your treatments. If your benefits are maxed before treatment ceases then we can file your health insurance for the remainder of your care. It is not our policy to send claims to any auto insurance carrier other than our patient's insurance carrier. We will also accept patients with an LOP from their attorney.

Initial _____

Medicare Patients:

I understand that Medicare does not cover the following services when rendered by a chiropractor: Exams, X-rays, Ice or Heat Therapy, Electric Muscle Stimulation, Ultrasound, & Supplies or Supports recommended for my condition.

In addition, **Spring Spine Center** does not file secondary insurance claims; however, usually Medicare will forward the claim to the secondary insurance carrier for you. Contact Medicare directly concerning this matter.

Initial _____

Consent to Treat Minor

I hereby authorize **Dr. Smith** and any staff member he may designate as assistants to administer chiropractic care as deemed necessary to my child for the course of my child's treatment.

Initial _____

HIPPA/Consent

I understand that **Steven S. Smith, D.C., P.A.** may use and disclose my protected health information for the purposes of treatment, payment and health care operation. I also acknowledge that I have read, or received a copy of the Notice of Privacy Practices, which provides information about how **Spring Spine Center** and individuals involved in my care in the practice, may use and disclose my protected health information. As states in the Notice, I understand that I can contact the privacy officer at 281-376-1288 with any questions or concerns.

Steven S. Smith, D.C., P.A. has my permission to share health and account information with the individuals listed below:

Name	Relation
_____	_____
_____	_____
_____	_____

In general, the HIPPA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of (PHI) made by alternative means, such as sending correspondence to the individuals office instead of the individual's home.

Please indicate how you would like to be contacted:

- Home Phone: _____
- Leave message with detailed information
 - Leave message with call back number only
- Work Phone: _____
- Leave message with detailed information
 - Leave message with call back number only
- Cell Phone: _____
- Leave message with detailed information
 - Leave message with call back number only
- Written information:
- Mail to home address
 - Mail to work address
 - Fax to this number: _____

Claims for Workers Compensation

Patients should report the injury to the employer immediately after the incident, and you **MUST** have a claim number in order to file medical claims. Your employer may need to fill out information in order to submit claims to the insurance carrier. Workers compensation cases that are denied may then be submitted to health insurance carriers for payment, or be turned over to the patients cash balance. If you wish to appeal a denial a monthly payment arrangement will be necessary in order to avoid collection procedures.

Initial _____

Supports & Supplies

Dr Steven Smith may recommend a support or supply that aids in the recovery of injuries, or assists staff with the application of physical therapy. I understand should I decide to purchase said supports and supplies, my insurance carrier *may* determine that the support/supply prescribed for me is not medically necessary (non-allowable). Further, I agree to pay for this support/supply even if my insurance carrier decides it is not allowable (not covered under my benefits). I will be credited any payment towards the support/supply that my insurance company remits.

Initial _____

Thank you for reading and understanding our office policies. If you have any questions please let us know. By signing below you agree to all the rules and regulations set forth by Spring Spine Center that apply to your account.

Signature of Patient **Date**

Signature of Responsible Party **Date**