

DR STEPHEN POKOWICZ -

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ADVANCE NOTICE OF PATIENT RESPONSIBILITY

We are pleased you have entrusted us with your chiropractic care and we will do our best to help you recover from your current condition. The insurance industry has made many changes and there are so many different plans available through each insurance company. We want you to know that we will gladly submit your treatment to your insurance company if it is a company that our doctors participate with, however, that is not a guarantee of payment by the insurance company. Your health plan may refuse payment of a claim for some of the following reasons:

- Your insurance does not cover treatment for maintenance, chronic or pre-existing conditions.
- You have not met your calendar year deductible.
- There is a Co-payment or Co-insurance amount due.
- Our services are not covered by your plan.
- Your insurance company has determined that the services provided were not medically necessary.
- Your insurance denied authorization for treatment.
- You have exceeded your policy benefits.

We have a right to charge you a NO SHOW FEE of \$25.00 for each missed appointment.

Therefore, this advance notice is to inform you that:

_____ and or the subscriber: _____
(Patient) (Subscriber)

Is responsible for any balances due upon notification from your insurance carrier for any of the reasons stated above.

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any reason, our office cannot be responsible for this bill. It is your responsibility as the patient/subscriber to pay the denied amount.

Returned Check Policy: If a payment is made on an account by check and the check is returned as Non-Sufficient Funds, Account Closed, or Refer to Maker, the patient or the subscriber will be responsible for the original check amount in addition to a \$25.00 service charge.

By signing below, you agree to accept full financial responsibility as a patient who received medical services or responsible subscriber and you verify that you have read the above disclosure, understand your responsibilities, and agree to the terms.

Responsible Party (Please Print): _____

Responsible Party (Signature): _____ Date: _____