Patient Name: _____ Acct#_____
DOB: _____ Claim#_____

Financial Policies
Please read thoroughly!!

PLEASE CIRCLE ONE CHOICE:

1] PRIVATE PAY PATIENT: **Payment is due in full at the time of service.** (Arrangements can be made in advance with the Doctor and/or staff for payments. A signed agreement is required as well as a copy of your current photo identification.) We do not bill private health insurance, but we can provide you with a detailed receipt for your visits, known as a "super-bill", which you can submit to your insurance company for possible reimbursement according to your policy.

2] MEDICARE: It is our legal obligation to have a copy of your current insurance card on file.
*Medicare will pay 80% of **adjustments only** (after deductible has been met).
***Exams are required but not payable** by Medicare.
*X-rays are not required by Medicare, however, after an examination, the doctor may determine that x-rays are necessary in order to adjust you. He may take the x-rays in the office, have them sent over from another facility, or request that your M.D. order them to be taken at an x-ray facility. X-rays are not payable by Medicare when taken by a chiropractor.
*Medicare does not pay for adjustments that support chronic care or maintenance care. They cover adjustments only as part of an active treatment plan. As such you will be asked to provide the doctor and/or staff with information that allows us to create an active treatment plan for you. If Dr. Conklin determines that your condition is chronic, you may be asked to sign an Advanced Beneficiary Notice (ABN) which will allow us to collect payment from you in the likely event of denial by Medicare.
*If you have secondary insurance, please let us know so we can process accordingly.
You will need to pay your co-pay and any un-met deductible, as well as any non-covered items at the time of service. (Arrangements can be made in advance with the Doctor and/or staff for payments. A signed agreement is required as well as a copy of your current photo identification.)
*Ultimately you are responsible for any and all services your insurance does not pay for.

3] MOTOR VEHICLE ACCIDENTS: Treatment for injuries sustained in an automobile accident is covered by your auto insurance policy under the state required Personal Injury Protection (PIP) clause. All of your accident-related treatment up to your coverage limit will ***usually*** be covered, however; you must submit a completed PIP application to the appropriate insurance representative in order to have any medical expenses related to the accident considered for payment.
*Please note: **nutritional supplements,** and with some insurances, **pillows and ice packs are not a payable expense**. **You must pay for them at the time you receive them.** If your insurance decides to pay for any of the above, we will reimburse you accordingly.
*Ultimately you are responsible for any and all services your insurance does not pay for.
*If there is **NO PIP** coverage because of dispute and you have an attorney, please refer to Dr. Conklin before you start care for acceptance of your case. Ultimately the patient is financially responsible for all charges incurred. Your signature on the following page is an agreement by you to Assign Benefits to the Doctor for Direct Payment to the doctor of any settlement that may be paid to you for this case. This signed agreement is required as well as a copy of your current photo identification for our office to accept your case.

4] WORKERS COMPENSATION (ON THE JOB INJURIES): Treatment for injuries sustained in an **accepted** claim for a work place injury is covered by the Employer's Worker's Compensation Insurance. All your treatment will usually be covered. Completion of '827' form is mandatory for a claim to be processed for approval. Dr. Conklin is not part of any MCO (Managed Care Organization). We can refer you to someone that is if necessary.
*Please note: **nutritional supplements,** and with some insurances, **pillows and ice packs are not a payable expense. You must pay for them at the time you receive them.** If your insurance decides to pay for any of the above, we will reimburse you accordingly.

Total Family Chiropractic, PC D. Scott Conklin, DC 4309 SE Woodstock Blvd #120 Portland, OR 97206 503-777-4221

Patient Name: _____ Acct#_____
DOB: _____ Claim#_____

Pg 2 Financial Policies continued…

All patients are required to present photo identification such as current Oregon ID card or driver's license. We are legally required to have a copy of these items in the patient chart.

All patient information is kept confidential and maintained in a safe and secure manner.

We reserve the right to refuse service to anyone who does not comply with our office and financial policies as stated.

Release of Benefits and Information: I understand agree that **health insurance and accident insurance policies are an agreement between the insurance company and me. I also understand that it is my personal responsibility to contact my insurance company or plan and be fully informed about my insurance benefits and limits.** I have read and understand the Financial Policies of Dr. Conklin and Total family Chiropractic as they pertain to my particular situation. I acknowledge that I am personally responsible for paying any unmet deductible amounts, co-payments, co-insurance and any non-covered services or supplies at the time of service. I understand that I am financially responsible for all services provided to me and for any balance due, regardless of insurance coverage. I understand that any non-sufficient funds check(s) returned to Dr Conklin will be charged to a $10.00 handling fee per check. I further acknowledge that in the event of non-payment, I will bear the costs of collection and/or court costs, and reasonable legal fees.

I have read the Financial Policies agreement and agree to its terms.

I authorize my insurance benefits to be paid directly to D. Scott Conklin, DC / Total Family Chiropractic, PC.

I authorize my attorney to pay directly to D. Scott Conklin, DC / Total Family Chiropractic, PC, any settlement payment for this case up to, but not more then, the total medical expenses incurred for this case at this office.

I authorize the release of any medical information necessary to process claims with my insurance company, and/or other billing agents/agencies.

I have read and understand the Notice of Privacy Practices and a copy of that document has been provided to me.

I agree that a photocopy of this document shall be considered as effective and valid as the original.

This agreement may not be revoked unless express written agreement by this office has been issued.

_____ _____
Patient Signature Date

_____ _____
Parent/ Guardian (for minor) Date

_____ _____
Witness Date