



Policies & Consents

Long Chiropractic Center
406 S. Howard St.
Wittenberg, WI 54499

Phone: 715-253-2239 // Fax: 715-253-3331

www.longchirocenter.com

Welcome:

Welcome to Long Chiropractic Center! We appreciate your trust in selecting us for your health care needs. Long Chiropractic Center strives to provide the best care for all our patients and seeks to have our patients actively involved in their care and rehabilitation as much as possible. Our clients offer a variety of chiropractic treatments, exercises, therapies and modalities to best meet your needs. Chiropractic care is for the whole family. We care for individuals of all ages and welcome referrals.

Office Policies:

Firearms: Firearms are not allowed on the premises of Long Chiropractic Center.

Changes/Updates: Patient are responsible for promptly notifying the clinic of any changes in their insurance coverage, contact information, legal guardianship, or other pertinent data that may affect our billing or care.

Appointments: It is important that patients follow the recommended plan of treatment to maximize their healing and recovery time. If you need to reschedule an appointment, it is appreciated if you can contact our office within 24 hours prior to the appointment. Our clinic also will do our best to accommodate walk-in appointments or same-day appointment requests.

Financial Policies:

Payment Methods: Our clinic accepts Cash, Check, Credit/Debit Cards (MasterCard/Visa)

Claims Submission: As a courtesy, Long Chiropractic Center will submit claims to your primary insurance and, if applicable, your secondary insurance on your behalf. This includes Medicare and Medicaid. Please submit a copy of all insurance cards upon arrival.

Insurance Verification: As a courtesy, Long Chiropractic Center will call to verify benefits and eligibility; however, Long Chiropractic Center is not responsible for any erroneous data provided to us by your insurance carrier. Long Chiropractic Center does not guarantee that your insurance will pay. Patients are responsible for understanding their health care policy benefits and limitations. If for some reason your insurance claim is denied, you are responsible for the full amount of the bill. If you have any questions regarding your eligibility or benefit coverage, please contact your insurance carrier to discuss you policy.

Deductibles, Copays, Coinsurance, Non-Covered: Payment of deductibles, Copays, Coinsurance and Non-Covered items are due at the time of service. Please be prepared to pay upon appointment check-in.

Cash Discount: We offer a discount plan called ChiroHealth USA. This plan is a _____ Fee for one year and this will significantly discount your services. Payment must be received at the time of service for the discount to apply. Please inquire for details.

Work Comp: If a Worker's Compensation carrier does not accept liability, the patient will be financially responsible for all services.

Personal Injury & Auto: Charges will be submitted to the applicable insurance company (auto, health, liability, responsible party's insurance). Denied services will be the patient's responsibility.

Minor Patients: The legal guardian accompanying a minor is responsible to authorize treatment and provide payment for services. Billing statements will be sent to legal custodian.

Medicare: Please note that Medicare does not pay for all of your health care costs; however, even though Medicare may not pay for a service, it does not mean you should not receive that service. Medicare Part B recognizes payment for the following Chiropractic services only: Spinal Manipulation (a/k/a Chiropractic Adjustment).

A calendar-year deductible is required for all Medicare patients. After your deductible has been met, Medicare pays 80% of the approved Spinal Manipulation. The patient is responsible for the remaining 20% coinsurance.

Items not covered and the patient's full financial responsibility are: Exams, X-Rays, Extremity Adjustments, Therapies, Nutritional Supplements, DME's/Supports, Exercise Programs, and Maintenance Care. Please note that it is our policy to obtain x-rays and perform periodic Exams as part of our treatment protocol, even though they are Non-Covered services and the patient's financial responsibility. Patients will have an opportunity to decide if they would still like to receive the service(s) if not covered by Medicare via use of an Advanced Beneficiary Notice (ABN) form. **Non-Covered services such as those listed above are eligible for the Cash Discount as mentioned above. Please inquire if interested.

Medicare Supplemental Plan: Medicare supplemental policies are designed to coordinate with Medicare and are plan-specific. Larger co-payments and additional benefits may apply. Some supplemental plans may pay for Deductible and Co-insurance depending upon patient's policy. Please provide a copy of the Medicare supplemental insurance card at the same time the Medicare card is provided.

Medicaid: Please note that Medicaid covered services may vary by state. Medicaid recognizes payment for the following Chiropractic services only: Spinal Manipulations (a/k/a Chiropractic Adjustment) and X-rays when performed in conjunction with an Exam. Please note that it is our policy to obtain X-rays and perform periodic Exams as part of our treatment protocol, even though they are Non-Covered services and the patient's financial responsibility. Proof of

insurance eligibility is required each month Co-payments must be paid on the same day the services are provided. Non-Covered services are the patient's financial responsibility and due at the time of service **Non-Covered Services are eligible for the Cash Discount mentioned above. Please inquire if interested.** Patient will have the opportunity to decide if they would still like to receive the service(s) if not covered by Medicaid.

Supplements/ Durable Medical Equipment (DME): Payment for these items is due at the time of purchase.

Returns/ Exchanges/ Refunds: We do not accept returns or exchanges for opened or used items (supplements, DME's, Therapy items, etc.), unless under manufacturer's warranty. Other items may be returned to the clinic of original purchase unopened and unused within 15 days of purchase for a refund or exchange.

Account Questions:

Patient Account Questions: Contact the clinic at (715)253-2239 for account questions or to set up payment plans.

Consents & Authorizations:

Notice of Privacy Practices: I acknowledge that I have received the Notice of Privacy Practices and have completed the “Acknowledgement of Receipt of the Notice of Privacy Practices.”

Authorization for use & Disclosure of Protected Health Information (PHI) and Wisconsin & Minnesota Consent – I understand that by signing below I authorize the Use and Disclose of my Protected Health Information (PHI) described herein and in the Notice of Privacy Practices that has been provided to me. I also acknowledge that Long Chiropractic Center has reserved the right to make changes to the privacy practices as necessary. If Long Chiropractic Center makes any changes, a revised Notice of Privacy Practices will be provided to me. I understand those changes will apply to any of my PHI that Long Chiropractic Center maintains.

Check any additional use and disclosure authorization that may apply:

- I consent to disclosure of my patient health care records for disaster relief purposes as permitted by law.
- I consent to use and disclosure of my patient health care records to the following person(s), including those involved in my care or payment for that care. [Specify person(s) below]:

(Person Name)

(Relationship)

(Address)

(Person Name)

(Relationship)

(Address)

Unless indicated by me otherwise, Long Chiropractic Center may use professional judgement and experience with common practice to make reasonable inferences of my best interest in allowing a person acting on my behalf to pick up supplies, X-rays or other similar forms of PHI as applicable.

Copy of Consent – I understand I am entitled to a copy of this Consent and Policy Brochure and I will inform clinic staff if I choose to have a copy. The original will be retained in my patient file.

Effect of Declining Consent – I understand that this consent is a condition of my treatment with Long Chiropractic Center and if I decline not to sign this consent, treatment may be declined.

Right to Revoke – I understand this consent is in effect until I choose to revoke it and I have the right to revoke it at any time by giving written notice. I acknowledge that such revocation will

not affect any action Long Chiropractic Center took in reliance on this consent before receiving the revocation. I also understand that upon revocation, Long Chiropractic Center may decline to continue treatment.

Release of Information: I authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in my case.

Assignment of Direct Payment: I authorize any and all benefit payments to be made on my behalf directly to Long Chiropractic Center.

Financial Policies: I understand and agree to adhere to the Financial Policies as outlined above and described herein.

Office Policies: I understand and agree to adhere to the Office Policies as outlined above and described herein.

Diagnostic Procedures, X-rays& Examinations: I hereby request and consent to receiving Diagnostic Procedures, including X-rays, and Chiropractic Examinations from the Doctors of Chiropractic and/or licensed support staff employed by, associated with, or serving as back-up support for, Long Chiropractic Center.

This consent is for these procedures to be performed on me, or for the patient named herein (for whom I am legally responsible)

Patient Signature:

By affixing my signature below, I acknowledge that I have fully read and understand the items listed above. I hereby consent, authorize and acknowledge the policies, consents and items as listed above and described herein and as outlined within the Notice of Privacy Practices provided by Long Chiropractic Center:

Patient Name (Print)

Patient Signature

Date

Legal Guardian/Representative Name (Print)

Legal Guardian/Representative Signature

Date