Active Life Chiropractic

FINANCIAL POLICY

1900 E. Market St., Suite 2, York, PA 17402
Phone: (717) 751-0500 **Fax: (717) 814-5407**

605 St John's Rd, Camp Hill, PA 17011
Phone: (717) 737-3443

Nichole Lehman, DC / Active Life Chiropractic believes that part of a good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT: Payment is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or driver's license due to the many cases of identity theft.

INSURANCE: We are participating providers with several insurance plans. We will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed and are responsible for the balance in full. If we later receive payment for your insurer, we will refund any overpayment to you.

If **Nichole Lehman, DC / Active Life Chiropractic** is not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, you are expected to pay charges due at the time of service. Our office will provide you with a receipt that you may submit to your insurance company to request reimbursement. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the office is closed may be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self pay patients.

LATE CHARGES: Invoices are due and payable upon receipt. There will be a $15.00 rebilling charge on each monthly statement issued after 30 days. If your account remains delinquent after 3 billing cycles, your account will be turned over to collections.

RETURNED CHECKS: Returned checks will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30.00 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30.00 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in York County.

ACCOUNTING PRINCIPALS: Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

FORMS FEES: Completing insurance forms, copying medical records, etc., requires office staff time and time away from patient care for our doctor. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $25.00 per occurrence plus any applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records that are not based on a flat-rate charge are $1.46 per page for pages 1 through 20, $1.08 per page for pages 21 through 60, and $0.36 per page for pages 61 and up in accordance with the Department of Health Medical Records Fees. Active Life Chiropractic will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed the form authorizing records' release.

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BILLING OFFICE: If you have questions in regard to any of your billing statements, our staff at Active Life Chiropractic is available to assist you on Mondays, Wednesdays or Fridays. **Call (717) 751-0500.**

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to **Nichole Lehman, DC / Active Life Chiropractic** for charges not covered by the assignment of insurance benefits.

CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we may assess you a $25.00 missed appointment fee. New patient appointments will be subject to a $100.00 missed appointment fee. If a new patient misses two new patient appointments, you will no longer be accepted into the practice.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to **Nichole Lehman, DC / Active Life Chiropractic** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Nichole Lehman, DC / Active Life Chiropractic to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Nichole Lehman, DC / Active Life Chiropractic. I authorize Nichole Lehman, DC / Active Life Chiropractic to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

INSURANCES WE DO NOT ACCEPT: I understand that I, personally, am financially responsible to **Nichole Lehman, DC / Active Life Chiropractic** for payment of charges at the time of service and that Nichole Lehman, DC / Active Life Chiropractic will offer to provide me with a receipt that I may use to submit to my insurance company to request direct reimbursement for any applicable services.

SELF PAY PATIENTS: Our office has reasonable rates for all Point of Service (POS) patients. Patients who are POS are required to pay at the time of service as per insurance regulations. Charges for supplies and Quest Lab tests are due and payable upon receipt. Nichole Lehman, DC / Active Life Chiropractic does not make payment arrangements or extend credit. All services and supplies are expected to be paid in full at the time of service.

RELEASE OF INFORMATION: I hereby authorize and direct **Nichole Lehman, DC / Active Life Chiropractic** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____
Signature of Patient (or Guarantor, if applicable) Date

_____
Please print the name of the **patient.**