Patient Financial Responsibility Form

Because we are focused on overall health and wellness it is important to us that you understand the terms “Medically Necessary” and “Clinically Appropriate.”

“Medically Necessary”: Is defined by your insurance carrier as treatment or service that is specific to your diagnosis and which your insurance company will pay for per your contract with them. The insurer only pays for chiropractic care that has a direct connection to documented improved function. There may be specific limits to your coverage or specific services that are not covered and this also is determined by your carrier.

“Clinically Appropriate”: For example, if you have a neck or lower back condition, your treatment plan may have to be extended beyond the insurance company’s standardized limitations in order to provide you full pain relief. At some point later in your treatment, we may not be able to document significant improvements in range of motion or other objective functional capacity measurements as the insurers often require. Insurance companies often deny care at that point despite the fact that the treatment continues to manage, reduce or eliminate your pain. This is “clinically appropriate” for your circumstances, but may not be considered “medically necessary” by your insurance carrier.

Your insurance company makes the final determination on whether a service is medically necessary and will be covered by insurance.

Dr. Moran has advised me that:

1.) Many insurance companies permit collection of payment for services directly from the patient if the patient requests the services and if the patient is informed in advance that the services are not covered or may be denied as not medically necessary; and
2.) It is the patient’s financial responsibility to pay for these services.

I understand it is my responsibility to confirm my coverage with my insurance carrier and that Fountain Chiropractic Clinic may verify such coverage as a courtesy to me, but that Fountain Chiropractic Clinic cannot be held responsible or liable for inaccurate information provided to it by my insurance carrier.

My signature below acknowledges that:
1.) Fountain Chiropractic Clinic has discussed medical necessity limitations, clinically appropriate care, and the fact that my insurance company may deny treatment as not medically necessary;
2.) I have been informed of my financial liability directly to Fountain Chiropractic Clinic if my insurance company denies all or part of these services as not medically necessary;
3.) I fully accept the financial responsibility to pay Fountain Chiropractic Clinic for any services I choose which my insurance carrier deems to be not medically necessary.

Patient Name: ______________________________________________

Patient Signature: ____________________________________________

Date: _______________________________________________________
Fountain Chiropractic

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, “I” and “my” refer to the patient, and “Chiropractor” refers to Dr. Arnold A. Moran.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.
I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice’s Notice of Privacy Practices prior to signing this document (notice of privacy practices is posted on wall by the entrance). The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Fountain Chiropractic. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____________________________________  __________________________________
Signature of Patient or Personal Representative  Printed Name of Patient

____________________________________
Date of Signing