# Winchester Family Chiropractic, PLLC. Dr. A.C. Borromeo, V

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## Patient Financial Responsibility Form

Dear Patient,
Because we are focused on the 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.**
Winchester Family Chiropractic, PLLC 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 Winchester Family Chiropractic, PLLC may verify such coverage *as a courtesy to me*, but that Winchester Family Chiropractic, PLLC cannot be held responsible or liable for inaccurate information provided to it by my insurance carrier.

*Chiropractic adjustments*: includes the Pro-Adjuster or manual adjusting technique
*Passive Therapy:* includes electric muscle stimulation; mechanical traction; ultrasound
*Active Therapy:* includes exercises for strength, endurance, range of motion or flexibility
Other: _____

My signature below acknowledges that:

1.) Winchester Family Chiropractic, PLLC has discussed the 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 Winchester Family Chiropractic, PLLC if my insurance company denies all or part of these services as not medically necessary;
3.) I fully accept the financial responsibility to pay Winchester Family Chiropractic, PLLC for any services I choose (as described below) which my insurance carrier deems not to be medically necessary; and
4.) I have chosen to receive the following services:

The Doctors and staff at Winchester Family Chiropractic, PLLC want to focus on your health as the number one priority. To handle finances, we have three (3) options for you to choose from:

_____I choose to pay my bill on a budget plan. I agree to pay $_____ per month. This amount will automatically be debited on my credit card until my balance is zero.

_____I choose to pay for my patient portion care at the time of service and to be billed for services which were not covered by my insurance carrier.

_____I choose to pay $_____ in advance for the services I will receive for my condition. I will accept a monthly statement of my account status.

This arrangement does not involve an offer to provide unlimited services in exchange for a pre-paid fee, nor is it ensuring against any fortuitous event or any occurrence assumed by the parties to be beyond the control of either party. This is simply a payment in advance for actual services I have received or will receive. Nothing about the payment arrangement shall be construed as or shall constitute and offer to waive any portion of my co-payment, co-insurance, or deductible obligations.

I acknowledge I have been informed of and accept the responsibility of being fully and personally responsible for all charges incurred for my care either not covered by my insurance carrier or which my carrier denies as not medically necessary.

I acknowledge and understand that if I cancel my appointment no less than 24 hours prior, I will be subject to a fee of $25.00 and that fee will not be covered by my insurance. It is therefore my full responsibility to call and reschedule my appointment at least 24 hours before hand.

Patient Signature: _____

Print Patient Name: _____Date: _____