

## WELCOME TO COASTAL CHIROPRACTIC GROUP

Dear Patient:

The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff.

We ask that all our patients read our Financial Policy prior to receiving services. All policies mentioned on the following pages may apply to you, regardless of the title given to any section:

PLEASE READ CAREFULLY.

### HEALTH INSURANCE PATIENTS

\*Do you have health insurance?  YES  NO

Policy Holder Name: \_\_\_\_\_

Insurance Company/Plan Name: \_\_\_\_\_

ID#: \_\_\_\_\_

\*Any other Insurance?  YES  NO

Policy Holder Name: \_\_\_\_\_

Insurance Company/Plan Name: \_\_\_\_\_

ID#: \_\_\_\_\_

- Fees for any service rendered at this facility (or your unpaid insurance deductible and copayments) are due at the time of service. We accept cash, checks, and for your convenience, Visa, Mastercard and Discover.
- If your insurance company overpays us, any amounts in excess of your bill will be refunded to you. However, your policy may require you to return any excess of payment to the insurance company.
- All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- If your insurance company does not pay in full within 30 days, we ask that you contact the carrier to help expedite the reimbursement process.
- You may elect to pay in full for your care on each day of service if you wish to claim and be reimbursed directly from your health insurance and/or when your case settles. If so, we will be happy to supply you with the necessary Insurance billing forms.

## **GENERAL INFORMATION FOR ALL PATIENTS**

- **Payment for all services at Coastal Chiropractic Group is due at the time of service.**
- We accept cash, checks, and for your convenience, Mastercard, Visa, and Discover.
- We may require a copy of a major credit card, which will ONLY be used in the event collection for services rendered becomes problematic. We reserve the right to charge your credit card if payment is not made 30 days after services are rendered. We will take full responsibility for having this copy on file.
- We understand that temporary financial problems may affect timely payment of services rendered at the facility. We encourage you to communicate any such problems so that we can assist you in the management of your account and minimize any disruption of your care.

### **PENALTY FEES**

- *\$20.00 fee for checks returned to us by the bank*
- *1.5% per month interest for balances older than 30 days*
- *Unless an appointment is canceled at least 24 hours in advance, you will be charged a \$25.00 fee that is not reimbursed by health insurance. Availability is a serious issue when a patient is in pain. This courtesy is appreciated.*
- *If your account is seriously overdue and reasonable cooperation is lacking on your part, a collection agency will be hired at your expense to finalize your account.*

We appreciate you taking the time to read this carefully and to provide us with the necessary information. We will do everything possible to assist you in your recovery.

**I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE CONDITIONS SET FORTH IN COASTAL CHIROPRACTIC GROUP'S FINANCIAL POLICY. I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I WILL NOTIFY THE STAFF AT COASTAL CHIROPRACTIC GROUP OF ANY CHANGES IN MY HEALTH STATUS; PERSONAL, FINANCIAL OR ANY OTHER PERTINENT INFORMATION.**

---

PATIENT'S SIGNATURE

---

DATE

## RELEASE OF INFORMATION AUTHORIZATION

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Insured (print)

\_\_\_\_\_  
Patient's DOB

\_\_\_\_\_  
Insurance Policy ID#

\_\_\_\_\_  
Date

\_\_\_\_\_  
Group# and/or SS#(of patient)

- I authorize payment of medical benefits to be made directly to Dr. Alano for any services furnished me by him. If the current policy of my insurance company (or the party of my insurance company (or the party responsible for my care) prohibits direct payment to the provider, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Coastal Chiropractic Group  
Dr Mark V. Alano  
450 Hope Street  
Bristol, RI 02809

- I also authorize the **release of any medical or other information** which Dr. Alano deems necessary and appropriate concerning my physical condition.
- The above mentioned doctor has my permission to intercede, on my behalf, to the Insurance Commissioner in the case of unreasonable delay of payment.
- A photocopy of this assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Policy Holder (if different)