Priority Life Chiropractic and Massage, LLC
FINANCIAL POLICY

Chiropractic is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE
We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been pre-arranged and agreed upon. A payment plan can be established in writing.
Initial:_____

GROUP OR INDIVIDUAL INSURANCE
The benefits quoted to you (please refer to Insurance Verification Form on our website) or our office staff by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.
Initial:_____

"ON THE JOB" INJURY (Worker's Compensation)
If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.
Initial:_____

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.
Initial:_____

MEDICARE
We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.
Initial:_____

SECONDARY INSURANCE
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.
Initial:_____

INSURANCE ONE TIME AUTHORIZATION
I understand that my insurance is an arrangement between myself and my insurance company, NOT between Priority Life Chiropractic and Massage, LLC and my insurance company. I request that Priority Life Chiropractic and Massage, LLC prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the providers at Priority Life Chiropractic and Massage, LLC, that fees will be due and payable immediately.
Initial:_____

Assignment of Benefits
I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Priority Life Chiropractic and Massage, LLC.
Initial:_____

Release of Information
I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.
Initial:_____

Payment Agreement
I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.
Initial:_____

Signature of Patient: _______________________________________ Date: _________
Signature of Guardian: _______________________________________ Date: _______

Priority Life Chiropractic and Massage, LLC
3401 SE 192nd Avenue, Suite 107
Vancouver, WA 98683

Priority Life Chiropractic and Massage, LLC
PRIVACY POLICY

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations. You may revoke this consent at any time by notifying Priority Life Chiropractic and Massage, LLC in writing, except to the extent Priority Life Chiropractic and Massage, LLC has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosures that ECHC, P.A. may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.
In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.
You have the right to request Priority Life Chiropractic and Massage, LLC. to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Priority Life Chiropractic and Massage, LLC is not required to agree to requested restrictions. If Priority Life Chiropractic and Massage, LLC agrees to the requested restriction, Priority Life Chiropractic and Massage, LLC will honor the request and it will be binding on the office.
I hereby consent to the use and disclosure Priority Life Chiropractic and Massage, LLC, its workforce, and its business associates of my protected health information for the purposes of treatment, payment, and health care operations.

Signature:____
Date:____

Guardian Signature:____
Relation to Patient:____
Date:____

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