Chiropractic HEALTH & WELLNESS CENTER

Nathan L. Barkalow, D.C.
200 Oakridge Court
P.O. Box 667
Wautoma, WI 54982
Phone: 920-787-4715
Fax: 920-787-1083

Financial Policy & Patient Responsibility

Patient Name (Print): _____ DOB: _____

Self-pay/Cash services

All payments are due at time of service.

Insurance

As a courtesy to you, we will bill your insurance carrier on your behalf. As the insured, you are personally responsible for knowing and understanding your own insurance policy, including deductibles, co-payments, co-insurance, eligibility and coverage. Actual benefits are determined by your insurance company after a claim is received. Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility. In the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, you understand and agree to be fully financially responsible for payment of all costs incurred and agree to pay all charges accordingly. Co-payments need to be paid at time of service and any balance due thereafter.

Medicare

An Advance Beneficiary Notice stating that Medicare does not guarantee payment must be signed prior to receiving care. You agree to pay any balance after Medicare or your supplemental insurance carrier has responded to charges billed.

Medicaid

If you are a Medicaid patient, you are responsible for non-covered portions and spend-down requirements associated with your individual coverage. If at any time you are not eligible for Medicaid coverage and wish to be seen, you will be considered a self-pay patient and must make payment at the time of service.

Workers Compensation/Auto Accident/Personal Injury Claims

If a workers compensation injury/accident claim is denied, you are responsible for payment of the charges. For auto accident or personal injury claims, we will not accept third party billing if your case involves litigation. Our services are provided to you, not an attorney, and therefore you are ultimately responsible for the account. We will require you to make payments on the charges even if a third party will cover them.

Acceptance of Financial Responsibility

I acknowledge that I have read this agreement and am ultimately responsible for all charges incurred for services received.

Patient (Guardian) Signature _____ Date _____

Name (Print)_____ Relationship to Patient _____