BAYWEST HEALTH & REHAB

PIP W/C Slip/Fall LOP

Patient Name:______________________________________ Date: ______________

How did you hear about us? ____

Social Security #: _____________________ DOB: _____________ Sex: M F

Address: ____

City: ___________________________ State: __________ Zip: _______________

Phone #: ______________ Cell #: ______________ Email Address: ______________

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Spouses name: ___________________ Employer Name/Phone #: ______________________

Name of closest relative/friend not living with you: __________________ Phone #: _____________

Name of Primary Care Physician: ________________________ Phone #: _____________

Was this work/auto accident related? YES NO Date of Injury ______________

If work related, what is the employers name:___________________ Phone #_____________

Was this incident reported to your employer? YES NO

If yes, who was it reported to? ______________________ Phone# __________________

Is there an attorney involved? YES NO

Attorney Name: ____________________________ Phone #:___________________

Attorney Address: ____

Have you reported the accident/injury to your insurance company? YES NO

Name of Insurance Carrier:____

Name of Insured: ____

The relationship to the Insured (Circle): Self Spouse Parent Employee Other: ___________

Billing Address for Claims: ____

Phone # for Claims: ________________ Policy #: _________ Claim #: ___________

Adjuster Name: _____________________ Adjuster Ph#: ______________ ext ______

Does Patient Reside with Insured: YES NO

Does the patient own a vehicle in the State of Florida? YES NO

Did the accident occur in the State of Florida? YES NO If not, where? __________________

BAYWEST HEALTH & REHAB

Notice of Privacy Practices for Protected Health Information

Introduction

In the last few years, health privacy has emerged as a prominent health care policy issue at the federal level. Although Congress has recognized the importance of protecting confidentiality of health information, it has been unable to pass any comprehensive health privacy legislation. Congress did, however, give limited authority to the US Dept of Health and Human Services (HHS) to issue regulations protecting the privacy of health information. Understanding the genesis of the Federal Health Privacy Rule is important for understanding the scope of the federal rule and how it operates.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes a major initiative, known as the "administrative simplification provisions", intended to cut administrative costs by standardizing electronic health care transactions. Prior to HIPAA's passage, this move towards standardization raised serious privacy concerns. To reconcile these competing priorities of safeguarding privacy and easing the flow of health data, Congress included in HIPAA a requirement
That if failed to pass comprehensive health privacy legislation by August 1999; the Secretary of the HHS would issue regulations. Despite the introduction of numerous proposals, Congress failed to meet its deadline, and the duty passed to HHS to promulgate health privacy regulations.

As required under HIPAA, the Secretary of HHS issued a final health privacy regulation in December 2000. After a short delay, the final regulation, known as the "Privacy Rule", became effective April 14, 2001. The Privacy Rule has the force of law. Compliance with the Privacy Rule is generally required by April 2003.

Although this rule is "final", that does not mean that it will not be changed. HHS has made clear that it intends to engage in additional rulemaking to substantively change the rule in the near future.

We Safeguard Information about your Health and Person:

We collect information from you and store it in a medical record as well as on a computer. All such information saved on the computer is password protected. Passwords are only afforded to the appropriate personnel. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you for the purpose of treating you in the most effective way possible. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians, and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers, and for healthcare operations.

Outside of our office, we restrict the disclosure of this information to those people, entities, and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal ad administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster Relief and Fund Raising

We will not use or disclose your medical information for any purpose note listed without specific written authorization. Any specific written authorization you provide may be revoked at any time by your written request.

Patient Privacy Rights:

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and receive a copy of your record. There will be a copy fee to provide this service to you. We must respond within thirty (30) days if the record is readily available and within sixty (60) days if it is not readily available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request, directed to our office, to amend your chart. We must respond within sixty (60) days.
- Receive an accounting of any disclosures made from your record over the last six years, beginning April 14, 2003. You can do this with a written request, directed to our office, to amend your chart. We must respond within sixty (60) days.
- Request restrictions as to the amount of medical information we disclose. This is limited as noted above, and your request may not supercede the typical disclosures noted above. You may revoke or restrict consent.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office.
- Receive a copy of this notice by printing it or with a written request directed to our office, and a copy of this notice will be given with all new patient packets.

We may contact you for appointment reminders and we may provide you with information about health related services and/or product benefits and services.

Each patient is given a copy of the Privacy Notice and has an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

If you have questions or would like to lodge a complaint regarding our privacy policy, you can contact our Privacy Officer at 727-372-0091.

If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.

Privacy Notice Receipt

I have received a copy of BayWest Health & Rehab's privacy notice as required by HIPAA.

Patient Signature: ______________________________ Date: ____________

Patient Name (Print): ______________________________

Witness Signature: ______________________________ Date: ____________

Witness Name (Print): ______________________________

BAYWEST HEALTH & REHAB
Accident Details/Injury Questionnaire

Please complete all that apply
For Auto Accidents, W/C, Slip/Fall

Today's Date ____________ Patient Name: ____

Please explain in full detail how this accident happened? ____

____

____

What body parts were injured?: ____

____

Have you ever had these complaints before? YES NO If yes, when: ____________________

____

Is this your first accident? YES NO If no, please explain: ____________________

____

Have you lost any time from work as a result of the accident? YES NO

Have you returned to work? YES NO On what date? ____________________

Please complete for Auto Related Injuries:

What was the date and time of the accident? ____

Which direction were you heading? (Please circle) North South East West

On which street/intersection? ____

Which direction was the other party heading? (Please circle) North South East West

On which street/intersection? ____

What type of vehicle were you driving? ____

What type of vehicle struck you? ____

Were the police notified? YES NO Is there a police report? YES NO Who was cited? __________

On which side were you struck (Please circle): Rear Front Left Right

Were you the...(Please circle): Driver Front Passenger Back Seat Other, pls explain: __________

Did you feel pain immediately after the accident? YES NO If Yes, please explain: ______________

____

Were you wearing your seatbelt? YES NO Were you ever rendered unconscious? YES NO

Did the airbag deploy? YES NO Were you treated at the accident site? YES NO

Did you seek treatment after the accident? YES NO Where? ____________________

What treatment was given? ____

____

Are you currently under another providers care for this accident (please list all)? YES NO

The provider's name (s)? ______________________________ Phone #: ______________

When was the last time that you were treated for this accident? ____________________

Symptom Survey
Please circle as many as apply

Patient Name ______________________________ Date ______________

Head: Headaches: Mild Moderate Severe How Often (circle)? ________ times per.... Day Week Month

Description of Pain: Sharp Dull Constant Intermittent

Location: Back of Head Forehead Temples Right Side Left Side Behind Eyes

---

Jaw: Pain: Right Left Both Clicking/Popping: Right Left Both

Neck: Description of Pain: Mild Moderate Severe Locations: Right Side Left Side Both

Are you having any of the following: Stiffness Muscle Spasm Grinding Sounds

Pain Increased by: Fwd Movement Backward Movement Rotate Head Right Rotate Head Left

Bend Head Left Bend Head Right

Upper Extremity:

Upper Arm Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Forearm Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Hand Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

---

Mid Back: Pain Location: Right Left Both Pain Level: Mild Moderate Severe

Type of Pain: Sharp Stabbing Dull Muscle Spasms: Right Left Both

---

Shoulder: Pain Location: Right Left Both Pain Level: Mild Moderate Severe

Type of Pain: Sharp Stabbing Dull

Low Back: Back Pain Level: Mild Moderate Severe

Low Back Pain: Right Left Both Upper Back Pain: Right Left Both

---

Lower Extremity:

Upper Leg Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Lower Leg Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Foot Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Please list any and all other problems you are having as a result of this injury ______________________________

____

____

____

Briefly describe how you daily activities have change due to this injury ______________________________

____

____

TEMPOROMANDIBULAR JOINT VISUAL INDEX

A. Ear Problem
1. Hissing, buzzing or ringing
2. Decreased hearing
3. Ear pain, headache, no infection
4. Clogged, itchy ear
5. Vertigo, dizziness

B. Eyes
1. Pain behind eyes
2. Bloodshot eyes
3. Eyes may bulge out
4. Sensitivity to light

C. Head Pain, Headache
1. Forehead pain
2. Temples
3. Migraine type
4. Sinus type
5. Shooting pain up back of head
6. Hair and/or scalp painful to touch

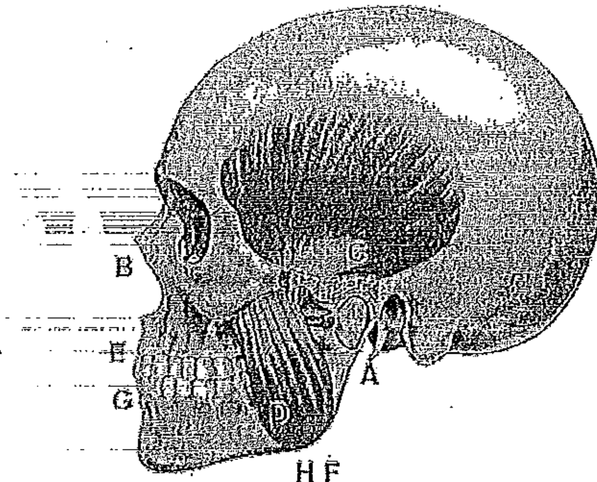
D. Jaw Problems
1. Clicking or popping in jaw joint
2. Grating sounds
3. Pain in cheek muscles
4. Uncontrollable jaw and/or tongue movements

E. Mouth Problems
1. Discomfort
2. Limited opening of mouth
3. Inability to open mouth
4. Jaw deviated to one side when opening
5. Locks shut or open
6. Can't find bite

F. Neck Problems
1. Lack of mobility, stiffness
2. Neck pain
3. Tired, sore muscles
4. Shoulder aches and backaches
5. Arm and finger numbness and/or pain

G. Teeth
1. Clenching, grinding at night
2. Looseness and soreness of back teeth

H. Throat
1. Swallowing difficulties
2. Laryngitis
3. Sore throat with no infection
4. Voice irregularities or changes
5. Frequent coughing or constant clearing of throat
6. Constant feeling of foreign object in throat



BAYWEST HEALTH & REHAB

Confidential Patient Health and History

Date ____________ Patient Name: ____

Have you ever had any of the following: (Circle Y or N)

Heart Disease	Y	N	Hepatitis A, B, or C	Y	N	Mumps	Y	N
Diabetes	Y	N	Lung Disease	Y	N	Chickenpox	Y	N
Prolapsed Mitral Valve	Y	N	Rheumatic Fever	Y	N	Whooping Cough	Y	N
Glaucoma	Y	N	Arthritis	Y	N	Scarlet Fever	Y	N
Tuberculosis	Y	N	HIV / AIDS	Y	N	Diphtheria	Y	N
Bronchitis	Y	N	Kidney Disease	Y	N	Smallpox	Y	N
Liver Disease	Y	N	Thyroid Disease	Y	N	Venereal Disease	Y	N
Measles	Y	N	Ulcers	Y	N	Anemia	Y	N
Stroke	Y	N	Mental/Psychiatric Disorder	Y	N	Bladder Infection	Y	N
Heart Attack	Y	N	Heart Murmur	Y	N	Migraine Headaches	Y	N
Pacemaker	Y	N	Colitis	Y	N	Polio	Y	N
Metal Implants	Y	N	Epilepsy	Y	N	Hernia	Y	N
Swollen Ankles	Y	N	Artificial Prosthesis	Y	N	Blood or Plasma Transfusions	Y	N
Sinusitis	Y	N	Hearing Loss	Y	N	Back Trouble	Y	N
Asthma	Y	N	Pregnant	Y	N	High Blood Pressure	Y	N
Hemorrhoids	Y	N	Cancer	Y	N	Low Blood Pressure	Y	N
Hives or Eczema	Y	N	Mono	Y	N	Date of Last Chest Xray		

Previous Hospitalizations/Surgeries/Serious Illness (Please explain) ________________________________

____

Please list any and all **ALLERGIES**: ____

Please list any medications that you take (prescription and over the counter) : __________________________

____

Patient social history:

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Rarely Moderate Previously, but quit: (date) __________ Current packs/day: _____

Use of Drugs: Never Type/Frequency: ______________________________________

Excessive exposure to(at home or at work): Fumes Dust Solvents Airborne Particles Noise

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Siblings			
Spouse			
Children			
Children			

Assignment of Benefits/Policy Rights

Patient Name: ____ Date: ____________

Policy Owner's Name: ____
Insurance Carrier Name: ____
Policy/Claim #: ____________________
Date of Accident/Injury: _____________

PATIENT: I, the undersigned patient, understand and agree that **BayWest Health & Rehab** (including any other subsidiaries, all its corporative, elected and appointed representatives and officials, or its assigns), requires payment at the time services are rendered, in consideration of Provider agreeing to not require at the time services are rendered, hereby assign the rights and benefits of insurance of the applicable personal injury protection, medical payments, and/or other insurance which may be available to pay Provider on my behalf to the said Provider. This assignment is for services and/or supplies rendered for treatment of personal injuries sustained in an automobile accident or incident on the above referenced date to me, the undersigned patient, who is covered by Personal Injury Protection (PIP) coverage or other insurance coverage under the above named Policy Owner's name, in accordance with Florida Statute 627.736.5. The undersigned is responsible for any applicable deductible or co-payment not covered by the said P.I.P. or other insurance policy rights, which I am assigning hereby, are to be covered through a policy of insurance with the company commonly known as the above referenced insurance company, under the above referred policy or claim number.

The assignment is intended to transfer all of the patient's rights to collect benefits from the said insurance company, including, but not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company which is obligated to provide benefits in any action including legal suit if for any reason the insurance company fails to make payments of benefits to which I am due. This Assignment further includes the right to collect payment for the reasonable costs connected with copying and mailing records to the insurer at the insurer's request and in accordance with Florida Statute 627.736 (6). This assignment also includes any right to recover attorney's fees and costs for any such action brought by the Provider as patient's assignee. I agree that the said Provider may select any attorney it wishes and understand and agree that the attorney selected by them may be different than the attorney handling my P.I.P./Bodily Injury claim or case. In the event of litigation or arbitration, I agree to cooperate with he said Provider and in any manner reasonably required. I understand that this cooperation may include giving sworn testimony at deposition, trial of the case, or any other proceeding that may be reasonably required and I also agree to execute any releases, settlement papers, and settlement checks. I further agree not to compromise or extinguish the value of this Assignment by taking a position inconsistent with the said Provider's pursuit of payment.

The Assignment of Rights and Benefits is intended to become effective immediately and binding upon the said insurance carrier upon my execution. I hereby instruct the said insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by the said Provider be placed in escrow and not disbursed until the dispute is resolved. As part of this Assignment of Rights and Benefits, I further instruct the insurance carrier to notify the Provider immediately of any dispute as to payment so that it may exercise its legal rights. I have read and understand the information herein, and it is true to the best of my knowledge and belief.

______________________________	______________________________	__________
Patient/Responsible Party Signature	Print Patient/Responsible Party Name	Date

Provider: The undersigned, on behalf of the above-referred provider, hereby accepts assignment of the insurance right and benefits for the services rendered to the above-referenced patient, and to be paid directly to the above referenced Provider under the above referenced patient's P.I.P. or other insurance coverage with the above referenced insurance carrier and in accordance with Florida Statute 627.736 et. Seq.

By: ______________________________ Date: ____________
Authorized Agent/Representative

BAYWEST HEALTH & REHAB
Office Financial Policy

Date: ____________ Patient Name: ____

Basic Policy:
Payment for service is due in full at the time that service is provided in our office.

For Patients With Insurance:
We bill most insurance carriers for you, assuming that you provide the correct insurance information. As the patient/responsible party, you should be aware of your plan limitations and benefits. Copays and deductibles are due at the time of service. We do not routinely research why an insurance carrier has not paid or why it has paid less than was anticipated. However, if you need help understanding your explanation of benefits from your insurance carrier, we will be happy to explain it to you to the best of our ability. It is not the responsibility of this office to obtain authorizations or verifications of coverage. Ultimately, any remaining unpaid balance is the responsibility of the patient/responsible party.

Non Covered Services:
Any services/supplies not covered by your insurance carrier (at the time of service/when supplies are given) will require payment in full at the time of service or upon notice of insurance carrier denial. It is not the responsibility of this office to confirm or verify your insurance coverage. Please know what your plan limitations are.

Personal Injury Cases:
This office will bill for any auto accident or other liability or lawsuit related cases as a courtesy to you. It is your responsibility to provide us with the car insurance carrier name and corresponding information prior to your visit in order to obtain proper authorization. Understand that only injuries which have a direct correlation to the personal injury case shall be handled in this manner. Any treatment received which is not related shall be dealt with separately and shall remain your responsibility.

Workers Compensation:
If your injury is work related, it is your responsibility to provide us with the case number and carrier name prior to your visit in order to obtain proper authorization. We will be happy to bill your workers compensation insurance company as a courtesy to you. Understand that only injuries which has a direct correlation to the work related injury shall covered by your workers compensation insurance company. Any treatment received which is not related shall be dealt with separately and shall remain your responsibility.

Missed Appointments:
In fairness to other patients and our physicians, we require at least a 24-hour notification of an appointment cancellation.

Assignment of Insurance Benefits (Health Insurance):
Patients with insurance please read and sign below that you understand and agree with the following statement:

Authorization to Administer Treatment:
I hereby give permission to the physician and staff at BayWest Health & Rehab to administer treatment, prescribe testing procedures indicated by the physician, as he/she may deem necessary in the diagnosis and/or treatment of my condition.

Authorization to Release Medical Information:
This authorization or photocopy hereof will authorize BayWest Health & Rehab to furnish all information on record regarding my condition while under observation or treatment, including the history obtained, x-rays and physical findings, diagnosis and prognosis. This authorization also allows any and all records to be released to BayWest Health & Rehab.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to BayWest Health & Rehab. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges which remain unpaid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I have read, understood, and agreed to the above financial policies for payment of professional fees.

Signature: ______________________________________ Date: ______________
Policy Holder/Responsible Party

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

CLAIM # ______________________________

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

____

____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

______________________	______________________	______________
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in **a substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand):*

______________________	______________________	______________
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

CLAIM # ______________________________

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1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

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FINANCIAL POLICY

PATIENT NAME ____

At BayWest Health and Rehab your pain is our priority. It is our sincere desire and goal to see you get well and stay well. The treatment and services our physicians prescribe and recommend are 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. Please understand, regardless of the coverage which you have, BayWest will only suggest the chiropractic care which our physicians feel best suit your specific situation. We ask that you read and understand our financial policy as it applies to your particular situation. If you ever have any questions or concerns please feel free to ask.

PATIENTS WITHOUT INSURANCE
We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card or Visa. Other payment options may be available.

GROUP OR INDIVIDUAL INSURANCE
OR MANAGED CARE PLANS
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"ON THE JOB" INJURY (Worker's Compensation)
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. 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 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. *Pay cash for your care and we will submit reports whenever necessary.*
2. *We will bill (accept assignment) from the Med Pay portion of your auto insurance.*
3. *We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.*
4. *We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.*

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 1 (one) year after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services may be considered due immediately. We are very aware of the sometimes lengthy delays in the legal arena. Rest assured we will not attempt to collect on monies due while your case is still pending.

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%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of BayWest Health & Rehab. I understand that my insurance is an arrangement between myself and my insurance company, NOT between BayWest Health & Rehab and my insurance company. I request that BayWest Health & Rehab 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 doctors at BayWest Health & Rehab that fees will be due and payable immediately.

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Patient's signature (or guardian if patient is a minor) Date

Notes: