CHIRO KINETICS CHIROPRACTIC FINANCIAL POLICY

WORKERS COMPENSATION INSURANCE CLAIMS

The following policy applies to patients who are being treated for a work-related injury or illness, and who have filed a Workers' Compensation Insurance claim.

By signing this form, you agree to comply with all the policies listed below.

1. By law, the State of California prohibits anyone from denying you the right of receipt of benefits in the event that you need to file a Workers' Compensation claim for a work-related injury or illness. You are responsible for reporting the injury to your employer, prior to receiving health care treatment. If you do not report your injury, you may be responsible for your charges at this office. Your employer needs to authorize your claim so that you may receive the health care treatment you need. The authorization needs to be obtained in writing; your employer should have the proper form(s) necessary for authorization. Chiro Kinetics will handle all billing and collection for services rendered on your Workers' Compensation claim, providing all necessary authorizations and forms are completed and received by us. Once the insurance company accepts the claim, Chiro Kinetics will accept the compensable amount as stated by law as payment in full for services rendered. If, however, there is a dispute between Chiro Kinetics and the insurance company regarding the compensable amount according to the law, the patient agrees to sign the appropriate forms and appear in court with Chiro Kinetics to resolve the dispute.

2. The patient, or the person who is financially responsible for the patient, hereinafter referred to as “patient", agrees not only to provide Chiro Kinetics with all the proper authorizations and forms necessary for us to collect on the outstanding balance, but to inform us of any denial of claims that may occur. You also agree to inform us in the event that you obtain legal representation in an attempt to go forward with your claim, after denial has taken place. If judgment is not in your favor, you will be responsible for the balance owing for your care received at Chiro Kinetics, and the balance must be paid in full within 7 days of the judgment. The patient agrees to have a valid credit card number on file with Chiro Kinetics at all times, and authorizes Chiro Kinetics to use the credit card number for payment if the amount owing after denial of the claim or after settlement of a disputed case is not paid in full in the agreed upon amount of time. If Chiro Kinetics does not receive payment in full within 7 days, Chiro Kinetics will assess a late fee on the outstanding amount at the rate of 1.5% per month. Any returned payments will be assessed a $35 service fee (will increase as bank charges increase), which will be added to the outstanding balance of the account

3. The patient agrees to follow the care program recommended by the Doctor, so that full benefit of the healing process will occur. If the patient discontinues care, against the Doctor's recommended care program, the patient understands that this may adversely affect the patient claim. As well, this will automatically discontinue the Workers[1] Compensation claim, and the case will be closed. When the Workers’ Compensation Insurance stops paying for your care, you will need to pay for further treatment yourself or with your medical insurance.

4. After final resolution of your Workers' Compensation claim or if your Workers' Compensation claim is discontinued, Chiro Kinetics may recommend further treatment to ensure that the patient remains in good health. If the patient decides to accept further care, any amount incurred must be paid in full at the time of the visit Chiro Kinetics does not extend credit. If the patient decides on further care after the resolution of the Workers' Compensation claim, the patient will be required to read and sign our office policy for a cash based treatment plan.

By signing this agreement, you agree that you have read and understood the above.

_____ _____

Signature of the financially responsible party Date

_____ _____

Print name of the person financially responsible Social Security number of the financially responsible perso

_____

Visa, MasterCard. Am. Express. Discover Card number of financially responsible person

_____

Patient name (if other than financially responsible person)

_____ _____

Expiration Date V-code

_____ _____

Witness Date