WELLCARE
CHIROPRACTIC CENTER

230 Lowell Street, Wilmington, MA 01887

(978) 658-7700 • (978) 658-7703 fax

INSURANCE FINANCIAL POLICY & RECEIPT OF PRIVACY NOTICE (HIPPAA)

Insurance Financial Policy Assignment

You have selected to use your insurance benefits to assist in your financial obligation to Wellcare Chiropractic Center (WCC). At WCC, we offer the option of **insurance assignment** strictly as a courtesy to our members, and, as such, our members must understand and agree to the following:

1. You are a cash member until you bring in your insurance card and this office both qualifies and accepts your coverage.

2. While we make attempts verify benefits on your behalf, the benefits quoted to us by your insurance company are not a guarantee of payment. **You are responsible for full payment for all services rendered.**

3. **Co-insurance/co-pays/deductibles must be paid at the time of service**.

4. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in your recovery of your claim, and as such time after 90 days you are solely responsible for payment in full for any outstanding balance.

5. In the event you discontinue or voluntarily change your care against the doctor's recommendations, you are responsible for payment of any outstanding balance, and the courtesy of insurance assignment is immediately discontinued *(as per health insurance regulations)*.

6. In the case of a managed care policy where there is a limitation of visits and fees, you understand and agree that you are required to complete the recommended series of visits and be totally responsible for payment of services rendered at regular fees or set by secondary/medical discounted plan.

7. We have a minimum 12 hour cancellation notice for chiropractic visits. **Missed appointments or cancellations made less than 12 hours will incur a $40 missed appointment fee which is NOT covered by insurance.**

This *Insurance Assignment Policy* must be followed. Your signature is an acknowledgement that our office has explained the policy to you, and that you understand it, and you accept full financial responsibility.

I have read and understand this policy.

Member Name (please print) _____ Signature (*if patient is under 18)* _____

Guardian Name (please print) _____ Relationship to Patient _____ Date _____

Receipt of Privacy Notice (HIPPAA)

I have read, understand and agree to what is stated in both pages of the Wellcare Chiropractic Center, Inc. Privacy Notice, as acknowledged below by my signature.

Member Signature _____ Date _____

Parent/Guardian Signature *(if patient is under age 18)* _____ Date _____