

# Pinkus Family Chiropractic

## METHOD OF PAYMENT

I will be paying today by: Cash\_\_\_\_\_ Check\_\_\_\_\_ Credit Card\_\_\_\_\_

\_\_\_\_\_ 1. I will PAY AT THE TIME OF SERVICE. I understand that there will be a discount for the adjustment fee to do so.

\_\_\_\_\_ 2. I have BLUE CROSS BLUE SHIELD/CBA/CIGNA/AETNA/OTHER MAJOR MEDICAL insurance which may include benefits for Chiropractic Care. I understand that I may have a co-payment to make and will do so at each visit, if so. My policy may have a deductible which I will be responsible for. I also understand that my policy may have limitations and that I may be responsible for additional charges.

\_\_\_\_\_ 3. I have Medicare Insurance and I understand that it does not include benefits for digital scans or examinations. Therefore, I will be responsible for a \$45 charge upon my first visit and any future/additional examinations or digital scans that may be required. I also understand that there will be a deductible that I have to meet each year. I will furnish Dr.'s Brenton or Katie Pinkus or the staff any necessary information to bill for my office visits.

\_\_\_\_\_ 4. I have Medicaid Insurance. I understand that it does not include benefits for digital scans or examinations. Therefore, I will be responsible for a \$45 charge upon my first visit and any future/additional examinations or digital scans that may be required. I will furnish Dr.'s Brenton or Katie Pinkus or the staff any necessary information to bill for my office visits. I understand that Medicaid has limitations for patients under the age of 12, including needing a referral from my child's Primary Care Provider ( If I do not get this referral for my child then I will be responsible for the charges) Therefore, because Medicaid does have limits on coverage, I understand that I may be responsible for additional charges.

\_\_\_\_\_ 5. I have been INJURED AT WORK, and will furnish the necessary information to Dr.'s Brenton or Katie Pinkus or the staff within 7 days of my first job injury appointment. I will give a Deposit of \$50.00 towards my first visit charges that will be refunded to me once my employer verifies my work injury.

\_\_\_\_\_ 6. I have been INJURED IN AN AUTOMOBILE ACCIDENT. I will furnish the necessary information to Dr.'s Brenton or Katie Pinkus or the staff with all the information to bill for this accident within 7 days. I authorize both my attorney and or the insurance company to pay directly to Dr. Brenton or Katie Pinkus such sums as are owed for services rendered me in relation to my motor vehicle accident. I hereby further give a Lien on my case to Dr.'s Brenton or Katie Pinkus against any and all proceeds of my settlement, judgment, or verdict which will be paid by my attorney or myself as the result of the injuries for which I have received care for by Dr.'s Brenton or Katie Pinkus.

\_\_\_\_\_ 7. I wish to bring in my family. We would like to take advantage of the Family Plan. I understand that this is only for patients who do not have the benefit of insurance, have a financial hardship and would not otherwise be able to afford the regular fees. All family members are required to come in on the same day. I understand that any bill or insurance paperwork is not included in this bookkeeping discount. I understand that I must pay for services at the time they are rendered.

\_\_\_\_\_ 8. I wish to take advantage of the Prepaid 10 Visit Plan. I understand that this is for anyone who does not have the benefit of insurance or decides not to process visits through insurance. This is a time of service discounted package. Full payment is required at the time of patient's first visit. I understand that my bill or insurance paperwork is not included in this bookkeeping discount.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered. I have read all of the above. I certify that this information is true to the best of my knowledge. I will notify Dr.'s Brenton or Katie Pinkus or staff if any changes occur in the above information.

SIGNED (Parent or Guardian)\_\_\_\_\_ DATE\_\_\_\_\_