

CONCERNING INSURANCE & ASSIGNMENT OF BENEFITS

In consideration of your undertaking to render care, I agree to the following:

- It is the policy of the HealthQuest Longevity Center to consider the payment for the services rendered as the full responsibility of the patient or his guardian.
- Patients who carry health care insurance should remember that professional services are charged to the patient and submitted to the insurance company.
- Insured patients are expected to take care of their fees as services are rendered. As a service we allow co-pay at the front desk for patients on a scheduled treatment plan. Unless we are under contract with your insurance carrier we can and may ask for payment in full.
 - Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account within the limits of our credit policy.
 - An "Attending Physicians Statement" of services on a HCFA-1500 claim form is mailed to your insurance company as a service. Please contact your insurance company representative or medical plan carrier if you have problems with how a claim was handled. We have a customary fee for additional itemization of services if it is not due to billing error in our office.
- An interest charge of 1.5% per month will be added to all balances that are 61 days or older, even if you have claims pending with insurance. We are not responsible for outstanding balances where claims are pending with insurance not due to an error by this office. We will assist where we can so that you may be reimbursed by your insurance but we will not wait for the reimbursement, the bill is the patient's responsibility.
- To ensure availability to those who need our services, a policy for missed appointments with no notification will be strictly enforced. The patient will be allowed one (1) missed appointment per calendar year.* Any subsequent cancellations/missed appointments will be charged according to the following penalty schedule:
 - **Missed Exam/Consult: \$75**
 - **Missed Office Visit/Manipulation: \$35**
 - **Missed Massage Therapy: \$45**
 - **Missed Therapy/Lab: \$25**

**A missed appointment by definition will include any and all procedures not cancelled within twenty-four (24) hours of the scheduled appointment time.*

Release of Information: You are authorized to release any information you deem appropriate concerning my medical condition to any insurance company, attorney, adjuster, or any other person necessary for you to process any claim for reimbursement of charges incurred by me at your treatment facility.

Right to Receive Payment: I authorize and assign to you, the medical provider, the right to receive direct payment from my attorney, insurance company, or any other party who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.

Assignment of Right to Sue: In the event of any insurance company, attorney, or other person obligated by contractual agreement to make payment to me for your service charges, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company, attorney, or person and authorize you to prosecute said action either in my name or your name and for you to resolve said claim as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account.

Attorney Direction: I hereby direct my attorney not to interfere with or claim any lien upon, any medical payment benefits to which I may be entitled from either my health insurance or medical payment sources. And if any said medical payment checks include my attorney's name, I direct my attorney to sign his name to these checks for the benefit of the medical provider herein.

I have read and understand the above policy. I realize that verification of my insurance coverage is not a guarantee of payment. All benefits payable are subject to policy terms and provisions. I also understand that final determination of my claim payment will be made when the claim is processed. I agree that any balance is ultimately my responsibility and understand that I will be responsible for any and all collections fees (**up to 50% of my balance**) should action need to be taken on a delinquent account.

Date _____ Signature _____