

***Kukurin Chiropractic, Acupuncture & Nutrition (KCAN)
Financial Agreement***

We are happy to assist you in processing your insurance claims. Many insurance carriers consider chiropractic services as a specialty, so the coverage may not be the same as indicated on your insurance card. We will call your insurance and verify coverage as soon as possible. We file insurance weekly.

Please make certain that all financial information provided to us is accurate. It is crucial that you report any changes immediately.

Fees & Network Participation

We are in-network providers with most insurance companies including Blue Cross Blue Shield, Aetna, Cigna, American Specialty Health and Medicare. Our fees are fair. Your agreement is between you and your insurance company. We must collect all co-pays, co-insurance and deductibles as per our agreement with your insurance carrier. Co-pays, co-insurance, deductibles and non-covered services are due at the time of your visit. Please do not request fee reductions from Dr. Kukurin. If you need to discuss fees and payment plans, please see Laurie or Cynthia. We will make every attempt to make your services affordable for you. If you are experiencing a true hardship, we will work with you again to make your treatment manageable. To qualify for hardship, it is KCAN policy for patients to apply for Care Credit and Advance Care Payment Plan at our office.

I understand that Medicare and other insurance plans will only pay for treatment that they deem to be medically necessary (sect. 18-21 (1)), after co-pays and deductibles have been met (sect. 1862 (a.1)). I agree to pay for services provided that are denied by my insurance plan; retrospectively or prospectively.

_____ (Patient Initials)

Accident Claims

Accident claims must be billed to the patient's car or health insurance. We do work on attorney's lien. If you are filing a lien, please do not ask for any reduction in fees due to an auto accident claim or worker's compensation claim.

Medicare Patients

As a Medicare provider, your chiropractor is required to consult and conduct a new patient examination before treating you. Medicare, however, does not reimburse for new patient chiropractic examinations. ***This is an out-of-pocket cost for you – the patient.*** Medicare only covers chiropractic adjustments of the spine and spinal subluxations. The new patient examination fee is \$125.00.

If you develop a new condition, a re-examination is required. Our fee is \$75.00. If you have not seen the doctor within three months, a re-exam is necessary to treat you.

Treatments on other areas of the body are considered non-covered services and patients are responsible for the fees. Medicare does not cover therapy including ultrasound, electronic muscle stimulation, traction, massage therapy, counter strain muscle work, rehabilitation, neuromuscular reeducation and acupuncture or laser therapy. The fees for these services range from \$20 to \$65 per treatment for each service.

This applies to Medicare patients and patients whose insurance is a Medicare Advantage plan. Examples of Medicare Advantage plans are Secure Horizons by United Healthcare, Cigna Medicare HMO/PPO plans, Security or Freedom BCBS plans. Medicare Advantage plans also are usually subject to a co-pay.

Medicare will cover 80-percent of the adjustment or spinal manipulation. Supplemental insurances will cover the 20-percent of the adjustment NOT covered by Medicare. Supplemental insurances will not cover any therapies or treatments not approved by Medicare.

If you have a true secondary insurance, therapies may be covered by your carrier. However, we require payment for services upfront. We will kindly bill your secondary insurance and if the doctor is reimbursed, we will issue a refund to you within 45 days of payment.

Please understand these are not our policies, but federal Medicare guidelines and policies. It's federal law; please don't ask us to break it!

I understand my Medicare coverage and I understand that I may be responsible for services NOT coverage by Medicare. I have also signed a Medicare ABN – Advance Beneficiary Notice required by Medicare.

_____ (Patient initials)

Patient Balance Policies

We do not send paper statements. This policy saves both of us time and money. We ask that you pay your portion at the time of the visit. Or as an alternative, you may leave a credit card authorization allowing us to charge your portion directly to a credit/debit card, once the insurance card has processed.

If you require a receipt or a copy of your account, we will be happy to email it to you. If a paper statement is required to be printed and mailed, there will be a \$5 service fee assessed to cover our costs.

If a claim remains unpaid for 60 days, is pended, or denied for any reason, except for an error on our part, we will bill your credit/debit card and will provide you with a printed claim form to assist you in getting paid. We will resubmit if we had an error. However, KCAN will not appeal or re-file claims due to improper information provided by the patient or carrier errors.

Cancellation Policy

Please be aware that KCAN requires 24 hour notice to reschedule or cancel your appointment. Failure to notify us within 24 hours to reschedule your appointment or cancel will result in a \$35 fee. Thank you for your understanding and compliance with scheduling appointments.

Payment Options

Please choose one:

Option 1: _____ **I prefer to pay at the time of the office visit and do not wish to leave a credit card on file.**

Option 2: _____ **I prefer to have my credit/debit card billed for my balance after my insurance has processed a claim. An email receipt will be emailed.**

Option 3: _____ **I need to make special arrangements regarding my account.**

I have read the KCAN billing policies and agree to pay in the manner indicated above. I understand there is a \$5 service fee for paper statements and agree to pay the fee. I also understand if my card is denied at the time the bill becomes due immediately. I agree to pay all collection costs, including attorney fees, incurred in collection for the services provided to me.

I authorized Kukurin Chiropractic, Acupuncture & Nutrition staff to contact me via email at _____@_____.

Patient Signature X _____ Date _____

Credit Card Revolving Payment Authorization

Acct #: _____ Security Code: _____

Expiration Date: _____ Billing Zip Code: _____

Cardholder Name: _____

This authorization is to be in effect for one year. I agree to abide by the terms of my Credit/debit card contract and authorize Dr. Kukurin/KCAN to charge my account according to my instructions above.

Patient Signature X _____ Date _____