# Flynn Chiropractic and Sports Rehabilitation

## Financial Policy

*We are committed to providing you the best possible care, and our staff is pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your responsibility in complying with our policies and procedures.*

1. **Insurance:**

Our staff will make every effort to verify your policy eligibility and chiropractic benefits. **It is always wise to take the time to call your insurance company on your own and inquire about your chiropractic benefits.** This information will be explained to you keeping in mind that benefit information we acquire from your insurance company is NOT A GUARANTEE OF PAYMENT AND IS SUBJECT TO CHANGES. We will outline the portion of deductible, copay or coinsurance (percent) that you are responsible for as per our verification.

Some policies will give authorization for care payable under a specific number of visits or a dollar amount they will pay out. We will do our best to help you stay abreast of the limitations BUT you are ultimately responsible for any expense incurred beyond these limitations. **It is important to understand and review the Explanation of Benefit sent to you by your insurance company.** This document outlines how each visit is processed, paid, and what is your remaining financial responsibility. Our staff is more than happy to go over this with you if you have questions.

*NOTE: Treatment is not designed based on what your insurance coverage allows but on what is deemed appropriate for optimum health. Please keep this in mind and know that not all services will be deemed necessary and be paid under your policies constraints. Know that we will do our best to keep you abreast of such issues and make our best attempt to help you get the care you need in a manner that you can afford.*

2. **Cash Patients:**
   Patients who do not have insurance will be responsible for all of the expenses incurred in our office. Please ask our staff about setting up a self-pay program. **Payment plans are available, as** it is important to us that financial demands do not take precedence over your maintaining an appropriate treatment plan.

3. **Payment:**
   We have an initial New Patient fee of $25 to set up your account, contact your insurance company, check on payments and send information as requested. This fee is not covered by insurance.

   **During initial active care we will collect your copayments at the end of your treatment week.** Patients who have completed their initial active care and have been released to maintenance care will be responsible for payment at time of service. Some insurance companies DO NOT reimburse for maintenance care appointments. In this case, you will be responsible for full payment of these visits. Please ask about payment arrangements in such situations.
   We accept cash, checks, Visa, Discover, and Mastercard. A fee of $30 will be charged to your account for any returned check.

4. **Work/ Auto Accidents:**
Our staff will gladly file medical claims due to automobile accidents with the patient's auto insurance Med-pay or third-party insurance with completion of our policy for Personal Injury patients and Med-pay information forms. If any attorney is involved, we will accept your case providing we have a letter of protection from your attorney, a signed lien, and completed office policy for Personal Injury patient form.

In this case of work-related injuries, we are able to file claims to your workman's compensation insurance as long as a case has been established by your employer. Please speak with our staff about this prior to your visit as that state law is specific about how we direct bill for your services.

5. **Supplemental Services:**
Orthotics, Cervical Pillows, Vitamin Supplements, and other products available for purchase in our office are payable in full at the time of service. **These items are not filed with insurance.**

6. **Cancellation Policy:**
If you are unable to keep your scheduled appointment, we require a 24-hour notice to avoid a missed appointment fee. A charge of $35.00 will automatically post on your account for any missed appointment that has not been rescheduled 24 hours prior.

I have read and understand the financial policy explained above. I agree to pay Flynn Chiropractic for services rendered as outlined in this document.

_____ _____
Patient Signature/Date Staff Signature/Date

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**Notice of Privacy Practices Release**

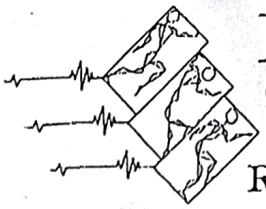
I have read and received a copy of the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Flynn Chiropractic and Sports Rehabilitation with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient Printed Name

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date

**Dr. Reid McCrea**



FLYNN
Chiropractic
& Sports
Rehabilitatio

8351-101STANDONSHIRE WAY • CREEDMOOR CENTRE • RALEIGH, NC 27615
919-676-6556 • 919-676-9767 (FAX)
www.flynnsportschiro.com

## Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedure including various modes of physical therapy, and if necessary, diagnostic x-rays on me or the following patien named, for who I am legally responsible:_____, by the chiropractic physicia and/or anyone working in this office authorized by the chiropractic physicians.

I further understand that such chiropractic services may be performed by Dr. Reid McCrea, and/or other licensed physicians of chiropractic who may treat me now or in the future at this office. I have had the opportunity to discuss with Dr. McCrea and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropracti carries some risks to treatment. I do not expect the physicians to be able to anticipate and explain all risks and complications. Further I wish to rely on the physicians to exercise judgment during the course of the procedur which the physician feel is in my best interests at the time, based upon the facts then known.

I have read the above and consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek at this facility.

**To be completed by the patient:**

_____
Print Name of Patient

_____
Signature of Patient

_____
Date

**To be completed by the patient's representativ if necessary, (e.g., If the patient is a minor or is physically or mentally incapacitated)**

_____
Print Name of Patient

_____
Print Name of Representative

_____
Signature of Representative

*"From Sports to Seniors"*