FREDERICK G. MAYER, D.C.
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OFFICE FINANCIAL POLICY

We know that choosing a physician is a very important decision and we thank you for choosing our office. You are required to read and sign the following office financial policy prior to the commencement of any treatment.

We charge what is usual and customary for our services. Payment is due when services are rendered, unless other arrangements are made in advance. We accept cash, checks, and credit cards. A $30 fee will be charged for returned checks. If at any time you find that you cannot fulfill your financial obligation, notify our office immediately so that payment arrangements can be made.

Please remember that your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. Verification of policy coverage by your insurance carrier does not guarantee payment. If necessary, it is your responsibility to obtain a referral/authorization for treatment from your medical doctor or insurance carrier.

Your insurance carrier can deny payment if they determine that a particular service is not considered "reasonable or necessary" by their guidelines. Most insurance carriers, including Medicare, will not pay for ongoing "treatment that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy which is performed to maintain or prevent deterioration of a chronic condition". You always reserve the right to appeal the lack of reimbursement for services with your carrier, pursuant to your health care insurance contract.

Our insurance billing is conducted by MTBC, a medical billing service. Your co-payment, as stated on your insurance card, is due at the time of service. Any additional patient responsibility will be billed to you once your insurance company has processed your claim. MTBC may call to remind you of any outstanding balance. You are responsible for full payment in the event that your insurance carrier rejects or disputes a claim.

If you have questions regarding a bill, call our office, or MTBC (866-592-6822). Please let us know whenever there are any changes in your personal health information, especially your address, phone number, and insurance plan.

AGREEMENT, RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I certify that I have read the above information, or that the information has been read or translated to me, and that I understand my rights and obligations as a patient under this agreement. I acknowledge that the information that I have provided is true and correct. I understand that I am fully responsible for any charges incurred for services rendered as well as any costs or fees incurred for collection of this account. I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further authorize my insurance carrier to make payment directly to my physician for services rendered to me and/or my dependents. My signature below also acknowledges that I have reviewed the office HIPAA Omnibus Rule Policy.

Print Patient Name _____ Date _____

Signature of Patient or Legal Representative _____

Legal Representative Relationship to Patient _____