

Financial Policy

We, Chiropractic Arts Clinic, LLC, are committed to offering the finest chiropractic health care available.

The responsibility for payment lies directly with the patient; however, we will submit all charges to your insurance company on your behalf.

We accept payment from the following insurance companies:

\*Sanford Medicaid (DOES cover extremities and electrical stimulation)

\*Sanford Health

\*North Dakota Medicaid (DOES NOT cover extremities or electrical stimulation)

\*United Healthcare

\*Medica

\*Blue Cross/Blue Shield

\*Medicare

\*\*Medicare patients are responsible for the cost of the *initial* examination, extremity adjustments and electrical muscle stimulation as these are noncovered services by Medicare.

\*Worker’s Compensation

Co-Payments are expected at the time of service. With any other insurance not listed above full payment is expected at the time of service. Chiropractic Arts Clinic will submit charges to your insurance company and whatever they pay will be sent to you by your insurance company.

If there are circumstances that prevent complying with this policy, other arrangements may be made. We appreciate your cooperation in this matter. If you have any questions, please do not hesitate to contact our office at 701-852-0158.

**Assignment of benefits**

*I authorize that any insurance benefits or reimbursement for services rendered with amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Chiropractic Arts Clinic, LLC*

**Release of Information**

I *authorize the release of any information concerning my health and healthcare services to my insurance companies, pre-paid health plan, or Medicare.*

**Payment Agreement**

*I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges*.

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Signature of Patient Date

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Signature of Parent/Guardian Date