Financial Policy & Agreement for Medicaid Patients 2011-2012

Name:_____ Medicaid ID:_____

Initial Date of Service:_____Today's Date:_____

We appreciate the needs of each and every patient that comes into our office. We work hard to see to it that you get the care and attention you need to heal. Please be sure to read, understand, and comply with our insurance and financial policy so that we may focus on what we do best: helping your body to heal!

Notice of Medicaid Policy: Covered & Non-Covered Charges

Your initial exam is mandatory in order for us to treat you. However, Medicaid does *not* cover the cost of the first exam. *Therefore we have reduced the fee due to financial hardship, but must require that you pay the reduced exam fee of $65 prior to (or at the time of) your first visit.* From that exam forward, Medicaid will pay for ten (10) adjustments, but no more than ten (10) adjustments *within the calendar year*. We bill Medicaid for you as a convenience and added service to you.

Should you need additional visits within the year, they will be available to you at a reduced rate due to financial hardship, on a pay- as- you- go basis; you will be advised of the cost and asked to sign consent ahead of time. We accept cash, checks, and major credit cards, for your convenience.

Medicaid also requires a re-exam before any future visits, due to financial hardship we reduce that fee to $35 for our established patients. You will be required to pay the $35 fee at the time of your re-exam also.

Acknowledgment

I understand and agree that I am responsible for $65 toward my first exam at Back To Health Family Chiropractic, P.C., and I hereby agree to pay that in advance or on the day of service. In addition, I understand that Medicaid will only pay for ten (10) adjustments in a calendar year, and I agree to pay for any additional visits at a reduced rate due to my financial hardship. I understand that these reduced rate visits are not something which Dr. Molly has to do, but that she & her staff are extending this to me as a courtesy. I understand that if a re-exam becomes necessary, Dr. Molly will allow me to pay for it at a reduced fee of $35, at the time of service, or before. These rates and this policy are extended to me due to my financial hardship and as a courtesy only and are not in any way mandated by law.

I agree to execute all insurance and other financial forms as needed in order to keep continuity of care and provide payments to the office.

Signed:_____ Dated:_____

Print Name:_____ Witness:_____