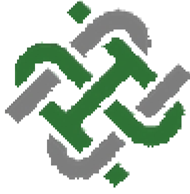


GRANDE RONDE CHIROPRACTIC CLINIC LLC
DR. CASEY A. MCKEOWN DC, DACBSP
1108 J Avenue La Grande, OR 97850
P: (541)963-0339
F: (541)663-8882
granderondechiro.com

Financial Policy

We strive to provide the highest quality health care, all the while maintaining affordability for you, the patient. We understand that even with insurance, most patients will experience at least some out of pocket expense.

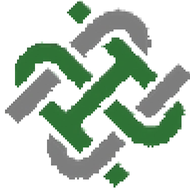
Participating Insurances
Our office will accept your insurance on assignment and do participate as preferred providers for many insurance plans. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your employer or insurance company. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery. We cannot be certain if your insurance covers chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is our policy and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays.

Non-Participating Insurances
We will gladly bill your insurance company for you, and will call to determine your chiropractic benefits. Payment is due at the time of service for all deductibles, copays, and non-covered therapies unless arrangements are with the office staff.

Patients without Insurance
We request that 100% of the examination and x-ray exam be paid at the time of the visit, unless other arrangements have been made. To qualify for our Time of Service Reduction in fees you must pay on the day the service was performed. We are happy to accept cash, check, Master Card, and Visa. No insurance will be billed.

Medicare
Our office accepts assignment from Medicare. Reimbursement is sent directly to our office in payment for chiropractic services that Medicare will cover. Medicare will ONLY cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

Secondary Insurance
Please inform us of any secondary insurance you may have. We will file and collect from your secondary insurance for services covered by the secondary payer. Flex Plans/Medical Savings Accounts Please inform us if you have a medical savings account, or a 'flex spending plan'. We will be happy to provide you with a statement of your charges for reimbursement. Health Saving Accounts (HSA)/High Deductible Health Plan Please inform us if you have an H.S.A. As Chiropractic is a qualified expense and can be paid for through your H.S.A. and billed to your high deductible health plan. Please read the following office policy regarding assignments:



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1. At the beginning of your treatment in our office we will verify your policy benefits. However, phone or fax verification of coverage is never a guarantee of payment.

2. Returned checks and balances over 90 days may be subject to additional collection fees and interest charges of 2% per month. Charges may also be made for missed appointments and those canceled without 24 hours' notice.

3. Your insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis.

4. You will be responsible for your full deductible and co-payment or coinsurance. Payment is due when services are rendered. If you're insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are of aware of the denial.

5. If you pay the full amount for services rendered each visit, you may qualify for our Time of Service (TOS) discount. You may then submit the bill to your insurance company for reimbursement.

6. If your insurance company has not paid a claim within sixty (60) days of submission, you agree to take an active part in the resolution of your claim. If your insurance company has not paid within ninety (90) days of submission, you are responsible for payment of any outstanding balance.
7. Our fees are considered usual and customary by most insurance companies, and therefore are covered up to the maximum allowance determined by each insurance company. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Personal Injury Protection (PIP) Worker's Compensation (WC) or Automobile Accidents
Please present your auto insurance card, Claim number, your health insurance card, and inform us if you have retained an attorney. There are two options available to the PIP patient:

1. Pay cash for your care and we will submit reports whenever necessary.

2. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 (six) months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

I have read and understand this financial policy. I realize that I am responsible for all charges incurred by me at Grande Ronde Chiropractic Clinic LLC. I agree to the above terms and authorize Grande Ronde Chiropractic Clinic LLC to collect from me payment if it is not received within ninety (90) days after the time of service.

Print Patient Name: ____________________________________

Guardian name: _______________________________________

Patient or Guardian's Signature: ___________________________ Date: ____________________