

## Health Insurance Election Form

This form is generally for non-accident cases. Check here  if your condition is due to an accident.

How would you like for us to handle your health insurance?

Please choose one option below:

Option 1 -- I Do Not Have Health Insurance and/or  
I Don't Want You to File My Health Insurance

I want the services we discuss, but either I don't have health insurance or I don't want you to bill or submit paperwork to my health insurance. You may ask to be paid now as I am responsible for payment. I understand that if my claims or forms are not submitted to my health insurance in a timely manner, my payer may decline to pay on my claims and I may not be able to appeal this decision.

Option 2 -- I Want You to File My Health Insurance and Also to Help Me Verify My  
Benefits. To Help You Get Paid, I'll Make Partial Payments and/or Sign an  
Assignment & Financial Policy

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. Please help me verify any Terms of Non-Coverage. If I have any questions, I will verify my coverage on my own. You may ask to be paid now for estimated co-pays, co-insurance, deductibles and other Non-Covered amounts. I understand that these are just estimates. In the event that my health insurance Denies Payment, I will be responsible for payment as described in your Financial Policy, but I understand that I will be able to appeal to my health insurance following its directions.

Option 3 -- I Want You to File My Health Insurance, But I'll Pay in-Full at the Time  
of Service or Pre-Pay. If Insurance Pays, You'll Give Me a Refund

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. However, you may ask to be paid now. If my health insurance does pay, you will refund any payments I made to you, less co-pays, co-insurance, and deductibles, and also discounts (Mandatory Fee Reductions) as described in your Financial Policy. In the event that my health insurance Denies Payment, I can appeal to my health insurance following its directions.

This election will remain in effect until a new election is signed with the Office's consent. This election supersedes any prior health insurance election.

Patient Name (Print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FINANCIAL POLICY AND AGREEMENT** (“Financial Policy” or “Agreement”)

I, the undersigned, in consideration of the Office’s services, agree to the following terms:

**Definitions.** In this Agreement, “Office” and “Clinic” shall refer to “Hoosier Chiropractor” dba “Health Connections” located at 12792 Ford Drive, Fishers, IN 46038.

**Personal Responsibility for My Charges.** I understand that I remain personally responsible for my Charges and that at any time; I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I understand that the Office’s Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office’s right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments. Returned checks and balances over 30 days may be subject to additional collection fees. I understand that if I discontinue care I will be required to pay off any account balance within 30 days. The Office may require a credit card on file to be charged the account balance on a monthly basis or the full remainder of account balance in case of discontinued care.

**Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges.** I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, “Deny Payment”). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is “not a covered benefit” under its policy or exceeds some other limitation. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I further understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, “Terms of Non-Coverage”). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I further agree that should the Office assist me in the verification process, I assume the risk that the Payer and/or the Office may in my opinion fail to accurately understand or communicate to me the Terms of Non-Coverage. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

**Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved.** Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, “Mandatory Fee Reductions”). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict “balance billing,” I hereby waive the application of such laws. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

**Authorization to Sign My Name on Payments; Transfer of Credit Balances.** I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, “by Hoosier Chiropractor” or “by Health Connections,” shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

**Miscellaneous Provisions.** Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office’s consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office’s “Assignment & Lien” and “Health Insurance Election” forms and further agree to the terms and definitions set forth in these documents. Said documents are incorporated herein by reference.

**I have read, understood, and agree to the terms of this Agreement.**

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_