

Mason Family Chiropractic
Marie S. Mason, D.C.
7C Chenoweth Drive Bridgeport, WV 26330
(304) 842-0601 Fax (304) 842-0602

Payment Options if you have no insurance: Payment is expected at the time services are rendered. If you cannot pay in full when services are rendered it is your responsibility to set up a payment agreement with our office manager.

****Forms of payment include: Cash, Check, Visa, and MasterCard.**

Payment Options if you have insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract in most cases.

1. **Co-pay's:** will be collected at each visit. Failure to meet co-pay requirements may result in the rescheduling of your appointment.
2. **Deductibles and Co-insurance:** If your insurance has a deductible that has not been met and/ or a percentage that is patient responsibility, this amount is expected at the time services are rendered.
3. **Secondary Insurance:** We do not bill secondary insurance. Unless your primary automatically crosses over to your secondary, you are responsible for the co-insurance and/or copay associated with your primary insurance.
4. **Referrals and or Prior-authorization:** If your insurance company requires that you have a referral and/or prior authorization, you are responsible for obtaining it. Failure to obtain the referral or authorization may result in a lower payment from your insurance company, making you responsible for payment in full.
5. **Non Covered Charges:** Should your insurance company determine a charge to be non-covered, you are responsible for full payment of the said charge.

Workers Compensation: We do accept properly referred workers compensation cases. If your claim is denied, you will be responsible for payment of services rendered.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Past Due Accounts: In the event your account becomes past due and good faith efforts to collect your debt have been exhausted, we may find it necessary to refer your account to a collection agency.

Missed Appointment Fee: Patients who miss two appointments must pay a security deposit of \$25.00 to reserve another appointment space. If patient keeps the appointment the \$25.00 deposit will be applied to the visit. Failure to keep appointment will result in forfeit of \$25.00 deposit.

Returned Check Charge: There is a fee of \$25.00 for any checks returned by the bank.

****Please turn this page over to complete****

Refunds: In the event of an overpayment on an account, a refund will be issued. If the credit is under \$25.00 the credit will remain on the account to be used at your next visit.

Obtaining a copy of Records: You will need to request in writing, and pay a reasonable copying fee of \$10.00 for charts 25 pages or more. There will be no charge for charts less than 25 pages. You authorize us to include all relevant information. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information.

Consent to Chiropractic Services: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I have had the opportunity to discuss with Dr. Marie Mason and/or with other office staff the nature and the purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I am informed and understand that in the practice of chiropractic, as in the practice of medicine, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocation and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures.

Office Hours of Operation:

Monday 8:30 AM – 1:00 PM and 3:00 PM – 6:00 PM
Tuesday 9:00 AM – 2:00 PM
Wednesday 8:30 AM - 12:00 PM and 3:00 PM – 5:30 PM
Thursday Closed
Friday 8:30 AM – 1:00 PM and 3:00 PM – 5:00 PM

RECEIPT OF MARIE S. MASON, DC HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT/POLICIES:

Please carefully review Marie S. Mason, DC's Notice of Privacy Practices and Financial Policy. The notice describes how protected health information about you may be used and disclosed and how you can access this information. It also describes the health information privacy practices of our business operations with our hospital and insurance carriers. Marie S. Mason, DC is committed to protecting the privacy of your health information as is required by law. Marie S. Mason, DC is required to provide you with an opportunity to review this notice. Once you have reviewed these policies and sign this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. Please ask the office staff for a copy if you would like to review such document.

Authorization To Bill Insurance:

By signing below, you also agree for us to bill your primary insurance carrier (if applicable) for services rendered. Certain procedures are excluded from some carriers and will be patient responsibility.

Print Patient's Name: _____ Date: _____

Signature: _____ Date: _____
(Responsible party)

Witness: _____ Date: _____