John H. Maher, DC

Valley Center Chiropractic
and Holistic Health Care

OFFICE POLICIES: In order to receive treatment, all patients must agree to sign the listed policies:
Initials

_____ FINANCIAL POLICY: It is the policy of Dr. John H. Maher and Valley Center Chiropractic and Holistic Care that all balances be paid in full at the time of service unless other arrangements, including third party assignment of benefits, have been made. We accept cash, check, Visa, Master & Discover Card, and Care Credit. Where agreed by the doctor, upon request payment plan arrangements may be made in advance.

_____ UNPAID BALANCES: Unless arrangements have been specifically made and signed all balances unpaid for longer than 30 days will accrue interest at the rate of 8.75%.

_____ HEALTH INSURANCE: Patients who have chiropractic insurance coverage must read and sign our Group and Individual Insurance Policy and the Assignment of Benefits.

_____ MEDICARE: I understand that Dr. John H. Maher is also a Participating Provider with Medicare. When applicable I understand that he will submit "assigned claims" for chiropractic adjustments on my behalf to Medicare according to the approved "limited charge" fee.

_____ PERSONAL INJURY: Dr Maher may agree to bill med pay or insurance carriers directly in the case of an auto or personal injury. Before accepting liens of any kind, the case will be discussed with the insurance company and/or the appointed attorney. Patient is fully responsible for the entire bill regardless of the monetary settlement agreement decided by the attorney and patient, or attorney and appointed guardian of patient.

_____ MISSED APPOINTMENTS: Except in the cases of unavoidable emergencies, patients will be charged $20 for failure to give 24-hour cancellation notice.

_____ CURRENT CONTACT DETAILS: Patient/guardian is responsible for keeping current all patient contact details – name, address, telephone number, email and any third party payer information.

_____ PRIVACY PRACTICES: I understand and agree to allow Dr. John H. Maher to use the Patient Health Information for the sole purpose of treatment, payment, healthcare operations, and coordination of care. (If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read our HIPPA PRIVACY POLICY before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.)

_____ RESPONSIBILITY FOR PAYMENT: I understand and agree that all services rendered are charged directly to me and that I am ultimately responsible for payment and the entire bill accrued. I also understand that if I suspend or terminate care any fees owed by me will be due immediately. If my account goes to collections for any reason I understand I am responsible for all legal/collection fees incurred.

_____ CONSENT TO TREATMENT: By signing this I agree to all of the above policies as well as give consent and authorize treatment for myself and/or the following minor, _____, age ____.

Signature_____

Print Name:_____

Date:_____

28714 Valley Center Rd, Valley Center, CA 92082
Tel: 760-500-6253; Fax: 760-751-3559; drjmaher@valleycenterchiropractic.com
www.valleycenterchiropractic.com

John H. Maher, DC
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GROUP/INDIVIDUAL INSURANCE:
Your insurance is an agreement between you and your insurance company, not between your insurance company and me, Dr. John H. Maher. I offer a complimentary benefits check to verify coverage; however, the benefits quoted to me by your insurance company are not a guarantee of payment.

As a courtesy to you, I will complete and file any necessary insurance forms at no additional charge. It is to be understood 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. If your insurance does not respond within 60 days, or if you suspend or terminate care, any fees for services will be due immediately.

ASSIGNMENT OF BENEFITS:
I, _____, authorize and direct my insurer or payor to pay directly to Dr. John H. Maher any or all benefits, that would otherwise be payable to me (or the patient, if signed by a responsible party), up to the amount of my bill, accruing to me in connection with my treatment by Dr. John H. Maher and Valley Center Chiropractic and Holistic Care.

I request that payment of authorized Health Insurance policy, Medicare or Med Pay benefits for services furnished to me by Dr. John H. Maher be made on my behalf to Dr. John H. Maher. In the event that payments are made to Dr. John H. Maher and me as joint payees, I agree to cooperate with Dr. John H. Maher to ensure that he receives all amounts due to him and Valley Center Chiropractic and Holistic Care.

I hereby authorize Dr. John H. Maher to pursue any means necessary to collect all charges on my account including follow up calls, appeals, arbitration, and civil suit, if allowable under the internal law of the State of California. In the event that Dr. John H. Maher elects to bring an appeal, lawsuit or petition for arbitration against the insurance carrier, I hereby assign to them my rights, title and interest under any insurance policy under which I am entitled to proceed for benefits, if allowable under the internal law of the State of California.

This assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim of any unpaid or underpaid bills for treatment rendered by Dr. John H. Maher.

I hereby certify that I understand and agree to the insurance policies and assignment of benefits set forth as above by Dr. John H. Maher and Valley Center Chiropractic and Holistic Care.

Patient's signature or authorized person acting on patient's behalf.

Signature_____

Print Name:_____

Date:_____

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