Babette Maiss,CMT,CLT,CMF
13 Williamsburg Lane
Chico, CA 95926
530-321-5668

PATIENT FINANCIAL POLICY

I am committed to providing you with the best possible care. If you have medical insurance, I will file your insurance claim as a “COURTESY” that I extend to all patients. If it is an insurance carrier that I participate with, I will have you pay any deductibles or co-insurance required by your policy at the time of service. However, I do need your understanding of our payment policy.

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENT HAS BEEN MADE AND APPROVED IN ADVANCE.

YOU MUST REALIZE THAT:

1. Your insurance is a contract between you, your employer, and the insurance company. I am not included in your contract.
2. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover.
3. The “Usual and Customary Charges” that may be quoted by your insurance company are charges that have been determine and set by your insurance company. They do not necessarily reflect my charges, or local, regional, or even national charges.

I must emphasize that as a healthcare provider, my relationship is with you, not your insurance carrier, and therefore financial responsibility is with the patient whom services are rendered. I do realize that there are times that a temporary financial problem may affect payment of your account. In that case, PLEASE contact me promptly for assistance so that I may set up a payment schedule for you. All credit will be applied to your account, unless a verbal or written request is placed with this office for a refund.

Insurance:

My office will kindly bill your insurance company. I participate with a number of medical insurance plans that I will contact to verify eligibility and benefits. Please realize that you have the ultimate responsibility of verifying the coverage with your insurance. You acknowledge that I may be an out of network provider with your insurance. You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. You will be responsible for any balance not paid or denied by your insurance carrier. Patients who do not supply accurate insurance information will be considered self-pay. You must inform my office of any changes in your insurance, as you are the policyholder and it is your responsibility.

Insurance Referrals:

If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from me. If a claim is denied due to a lack of referral you will be responsible for charges. You understand that you are financially responsible for claims denied or not covered by your insurance carrier for failure to obtain a referral.

Guarantee of Account:

In consideration of any and all medical services rendered to the named patient, I agree to pay Babette Maiss, CMT,CLT,CMF the charges for all services ordered by the prescribing doctor. If I have not followed the requirements for referral, second opinions, or pre- certification of my care, as outlined by my insurance carrier, I understand that I will be responsible for all charges that I incur. In addition, all unpaid balances will incur a monthly service charge and any legal or collection cost involved.

Returned Checks:

Any returned checks are subject to a $25.00 service fee. Any returned check must be resolved before any future appointments can be arranged.

Medicare, Medi-Cal:
If you are covered by one of the above, or any other government sponsored program, please discuss your payment situation with me prior to the date of treatment. You must present your "current" medical card prior to services being rendered. If you are involved in litigation of any kind that affects the payment of our services, I hold you responsible for payment of the fee.

Medicare Insurance Benefits: I certify that the information provided by me, in applying for payment under the Title XVIII of the Social Security act is correct. I understand that I am responsible for Part B deductible for each year, the remaining Co-Insurance, and any other amounts which may become due. I understand that if Medicare, Medi-Cal doesn't pay, I am responsible for payment, but I can appeal by following the directions on the MSN. The patient or patient's representative certifies that he/she has read and accepted the above, where applicable to the patient's condition and status, and further certifies that he/she is the patient or is duly authorized on behalf of the patient to execute such an agreement.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO PAY ANY BALANCE DUE TO BABETTE MAISS, CMT,CLT,CMF. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED FROM TIME TO TIME. BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE FULL UNDERSTANDING OF THE AGREEMENT AND INTEND TO FULFILL THE AGREEMENT. THIS AGREEMENT IS LEGALLY BINDING; HAVING ENTERED INTO THIS AGREEMENT VOLUNTARILY AND RECEIVING A COPY OF THIS AGREEMENT.

Name:
First_____

Last_____ Date:_____

Signature of Patient/Parent of Guardian if Patient is Under 18 Years of Age _____