GOLD STAR
Medical Business Services
"GIVING DOCTORS THE FREEDOM TO BE DOCTORS"

THE NATIONAL
WORLD'S LARGEST EVENT FOR CHIROPRACTIC BY FCA

The Empowered CA
From a Job to a Career

Lisa Maciejewski-West, CMC CMOM CMIS CPCO-I

Owner/Founder: Gold Star Medical Business Services

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LISA MACIEJEWSKI-WEST: CMC, CMOM, CMIS, CPCO-I

- Owner/Founder Gold Star Medical Business Services
- 44 years in Chiropractic
- Certified Medical Coder, Medical Office Manager, Medical Insurance Specialist
- Certified Professional Compliance Officer (CPCO-AAPC)
- Certified AAPC Instructor
- UVCA/ChiroCongress Insurance Helpdesk
- National Advisory Board, American Medical Billing Association
- Chair, Board of the TX State Office of Risk Management
- Member TX and GA Chiropractic Association Insurance Reimbursement Committee
- PROUD supporter of the Chiropractic Future Strategic Plan

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DISCLAIMER AND NOTICES

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Since you have an important responsibility in ensuring antitrust compliance in your healthcare activities, you should comply with the following guidelines:

Don't discuss with other providers your own or competitors' prices, or anything that might affect prices such as costs, discounts, terms of sale, or profit margins.

2. Don't make public announcements or statements about your own prices or those of competitors.
3. Don't make derogatory statements relating to the incompetence, fees or policies of insurance companies or companies providing ancillary services
4. Don't threaten or recommend an embargo of a certain company. This includes statements relating to recommendation of withdrawing from certain insurance plans
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Course Objective

To help CA’s understand the full spectrum of their jobs and give them the tools and empowerment to turn that job into a career.

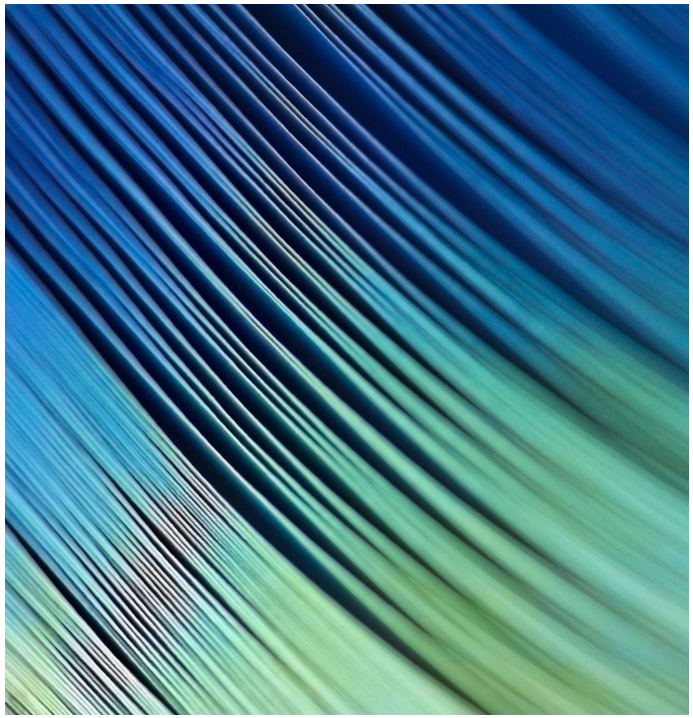
THE ROLE OF A CA

CA = Chiropractic Assistant

CT = Chiropractic Technician

CA's can be administrative (ie: Front Desk, Billing, Documentation Scribe) or Clinical (Rehab Tech, X-ray Tech, Patient Assistance/Case Manager)

Smaller Offices – CA's may have to do it all, until the practice grows enough to hire position players.



JOB DESCRIPTION: Front Desk CA

- Appointments
- Manage calls
- Manage Dr. Schedule
- Collections (OTC)
- Reminder Calls (if not automated)
- Reactivations
- **Traffic Control
- Data Collection/Updating information
- Patient Profiling – in PM system
- *Checking insurance benefits
- Patient Inquiries/Complaints

*May be handled by Billing CA, depending on the size

**May be handled by Back Office CT, depending on th

JOB DESCRIPTION: Billing/Insurance CA

- *Checking insurance benefits
- Coding reviews/Scrubbing claims
- Filing Claims
- Working Rejects/Denials/Appeals
- Post Insurance payments
- Balance Billing (Patient Statements)
- Working AR monthly
- Manage payment plans/pre-pay plans
- Patient inquiries regarding their insurance and account balance

*May be handled by Front Desk CA, depending on the size and makeup of the practice

JOB DESCRIPTION: Back Office/ Chiropractic Technician

*Traffic Control	Assist DC with Modalities (unattended)	Assist DC with Rehab (attended)	Document Clinical work done (Rehab Flow Sheets)
Assist DC with initial exam (review and record patient history)	Initial workup (height/weight/BP)	Patient Education	Documentation/Scribe
	Communicate with DC patient concerns, non-compliance	Take X-rays (if permitted by state law, and duly licensed)	

*May be handled by Front Desk CA, depending on the size and makeup of the practice

SOFT SKILLS

- Outgoing/Friendly
- Great Verbal Communicator
- Multi-Tasker/Good Time Manager
- Detail Oriented
- Professional Demeanor

TECH SKILLS

Operate Multi-Line Phone Systems

Great Computer Skills

Work with Multiple Screens

Work Simultaneously in Multiple Software Platforms – Toggle Master!

OTHER CA ROLES

- Office Manager
- Compliance Officer
- Case Manager
- PR CA (Marketing/Practice Building/Social Media)
- Scribe (exclusive)

CROSS TRAINING

Many chiropractic offices will cross train staff on a variety of duties

Helps small practices with coverage issues

Keep an open mind! “It’s not my job” should not be part of your conversation!

THE CA NO DOCTOR WANTS TO LOSE

Passionate about Chiropractic
Loyal
Dependable
Willing to adapt as the practice grows
Eager and Willing to learn, no matter how long they've been working
Willing to Jump in and Help where needed
Can work with minimal oversight
PROFESSIONAL
TRANSPARENT


FIRST THING FIRST
WHAT IS CHIROPRACTIC????

HOW CAN CHIROPRACTIC PHILOSOPHY HELP ME IN MY JOB?

Patients look at CA's the same way they do Nurses

They will ask you questions and voice concerns to you, sometimes INSTEAD of asking the doctor.

Questions can be centered around their health, appointments, therapies needed, billing, etc.

An entire staff that is on fire for chiropractic and understands the tremendous power and benefits of chiropractic will have better patient compliance and patient outcomes

IN A NUTSHELL

- Knowledge of Chiropractic will allow you to support your doctor, handle basic patient questions (and excuses), and increase patient retention
- Understanding the tremendous value of chiropractic, will help make it easier to collect fees for services rendered
- Understanding how and why chiropractic works will help you encourage referrals and personally refer more of your friends and family members for chiropractic care.

CHIROPRACTIC 101

THE DOCTOR OF THE FUTURE

THE CHIROPRACTIC BATTLE CRY

The doctor of the future will give no medication but will interest his patients in the care of the human frame, diet and in the cause and prevention of disease”—Thomas A. Edison (1847-1931)”

What is Chiropractic?

- Chiropractic is a branch of the healing arts which is based upon the understanding that good health depends, in part, upon a normally functioning nervous system (especially the spine, and the nerves extending from the spine to all parts of the body).
- "Chiropractic" comes from the Greek word *Chiropraktikos*, meaning "effective treatment by hand."
- Chiropractic stresses the idea that the cause of many disease processes begins with the body's inability to adapt to its environment. It looks to address these diseases not by the use of drugs and chemicals, but by locating and adjusting musculoskeletal areas of the body which are functioning improperly.

SOURCE: https://www.acatoday.org/about/history-of-chiropractic/

THE DOCTOR OF CHIROPRACTIC (DC)

A practitioner of chiropractic, a system of complementary medicine based on the diagnosis and manipulative treatment of misalignments of the joints. – Oxford Dictionary

UNDERGRADUATE DEGREE 4 YEARS

CHIROPRACTIC COLLEGE 3-3.5 YEARS

RESIDENCY/CLINICALS 1.5 YEARS (While in Chiropractic College)

DC'S CAN ALSO RECEIVE ADDITIONAL BOARD CERTIFICATIONS SUCH AS CHIROPRACTIC NEUROLOGY (DABCN), CHIROPRACTIC ORTHOPEDICS (DABCO), RADIOLOGY (DABCR), ETC.

Board certifications can take up to 2 or more years of specialized training.

DO YOU KNOW.....

- Where your Doctor(s) went to Chiropractic College?
- What their preferred Chiropractic technique is?
- What their treatment philosophy is?
- What kinds of patients do they prefer to treat? (Kids, Athletes, Geriatrics, etc)
- If they have any additional board certifications or training?

SCOPE OF PRACTICE

- Although there is significant variation in scope of practice from state to state, nearly all chiropractors use a variety of manual therapies with an emphasis on spinal and extremity joint manipulative procedures.
- Chiropractors are licensed as primary-contact, portal of entry providers in all 50 states and are trained to triage, differentially diagnose, and refer cases not amenable to chiropractic care.
- Chiropractors use 4 broad categories of therapeutic interventions: (*a*) joint manipulation and mobilization, (*b*) soft tissue manipulation and massage, (*c*) exercise and physical rehabilitation prescription, and (*d*) home care and activity modification advice. In addition, nutritional and dietary counseling, physical therapy modalities (eg, heat, ice, ultrasound, electromodalities), and taping/bracing are also used as adjunct procedures.

SOURCE: NATIONAL LIBRARY OF MEDICINE https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3716373/

KEY DEFINITIONS IN CHIROPRACTIC

- INNATE INTELLIGENCE: Innate Intelligence is defined as the body's innate ability to heal itself once the interference that causes dysfunction is removed.
- SUBLUXATION: Misalignments of the Spine and other joints in the body. Chiropractic treatment is focused on correcting Subluxations to allow the body's innate intelligence to heal itself
- WHOLISTIC MEDICINE: Treatment by natural means without the use of Drugs or Surgery

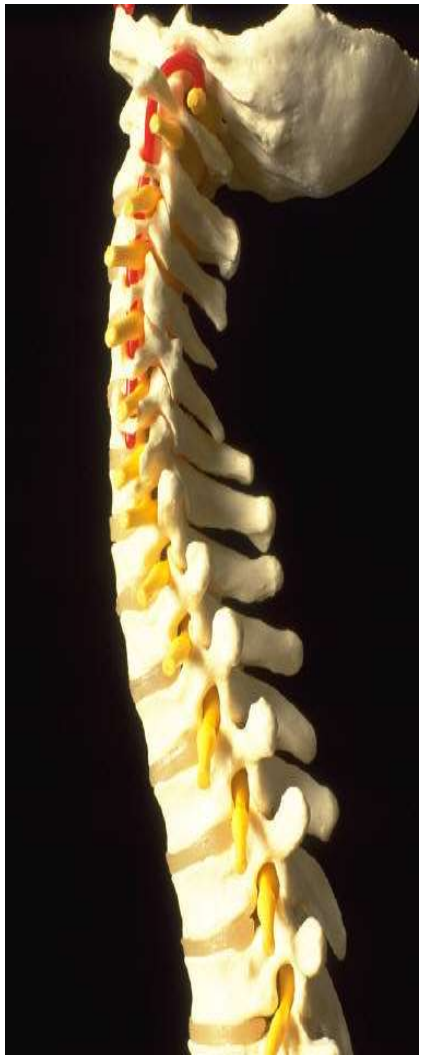
SOURCE: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4245701/

TREATMENTS AND MODALITIES

What is the primary method of treatment in Chiropractic?

The “adjustment or manipulation” is the prominent method of treatment.

An adjustment, as doctors of chiropractic use the term, means the specific manipulation of vertebrae which have abnormal movement patterns or fail to function normally. Once the DC has identified a problem with a vertebrae, he/she will begin care by way of adjustments or manipulations. Particular attention will be paid to that area of the spine where a spinal misalignment or "subluxation" has been detected. The adjustment is usually given by hand or a mechanical type instrument and consists of applying pressure to the areas of the spine that are out of alignment or that do not move properly within their normal range of motion.



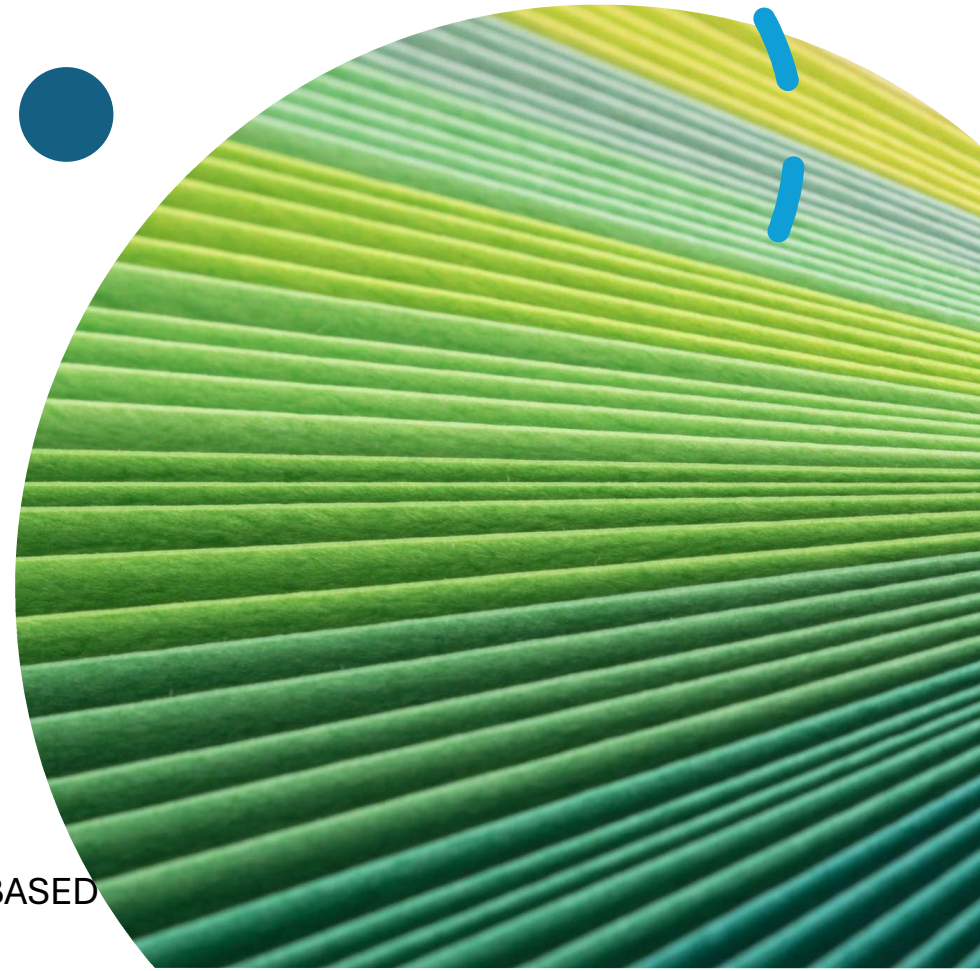
How Many Adjusting Techniques are there?

There are about 200 chiropractic techniques, most of which are variations of spinal manipulation, but there is a significant amount of overlap between them, and many techniques involve slight changes of other techniques.[1]

[1]https://en.wikipedia.org/wiki/Chiropractic_treatment_techniques

MOST COMMON TECHNIQUES

Diversified technique 95.9%,
Extremity manipulating/adjusting 95.5%,
Activator Methods 62.8%,
Gonstead technique 58.5%,
Cox Flexion/Distraction 58.0%,
Thompson 55.9%,
Sacro Occipital Technique [SOT] 41.3%,
Applied Kinesiology 43.2%,
NIMMO/Receptor Tonus 40.0%,
Cranial 37.3%,
Manipulative/Adjustive Instruments 34.5%,



MANY DC'S USE A COMBINATION OF DIFFERENT TECHNIQUES, BASED PATIENT AND THEIR NEEDS

SOURCE:

[1]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4245701/

[2]https://en.wikipedia.org/wiki/Chiropractic#

THE “STRAIGHT” VS. “MIXER” PHILOSOPHY

Over the years, the Chiropractic Profession branched into two main philosophies, commonly known as STRAIGHT Chiropractors or MIXERS.

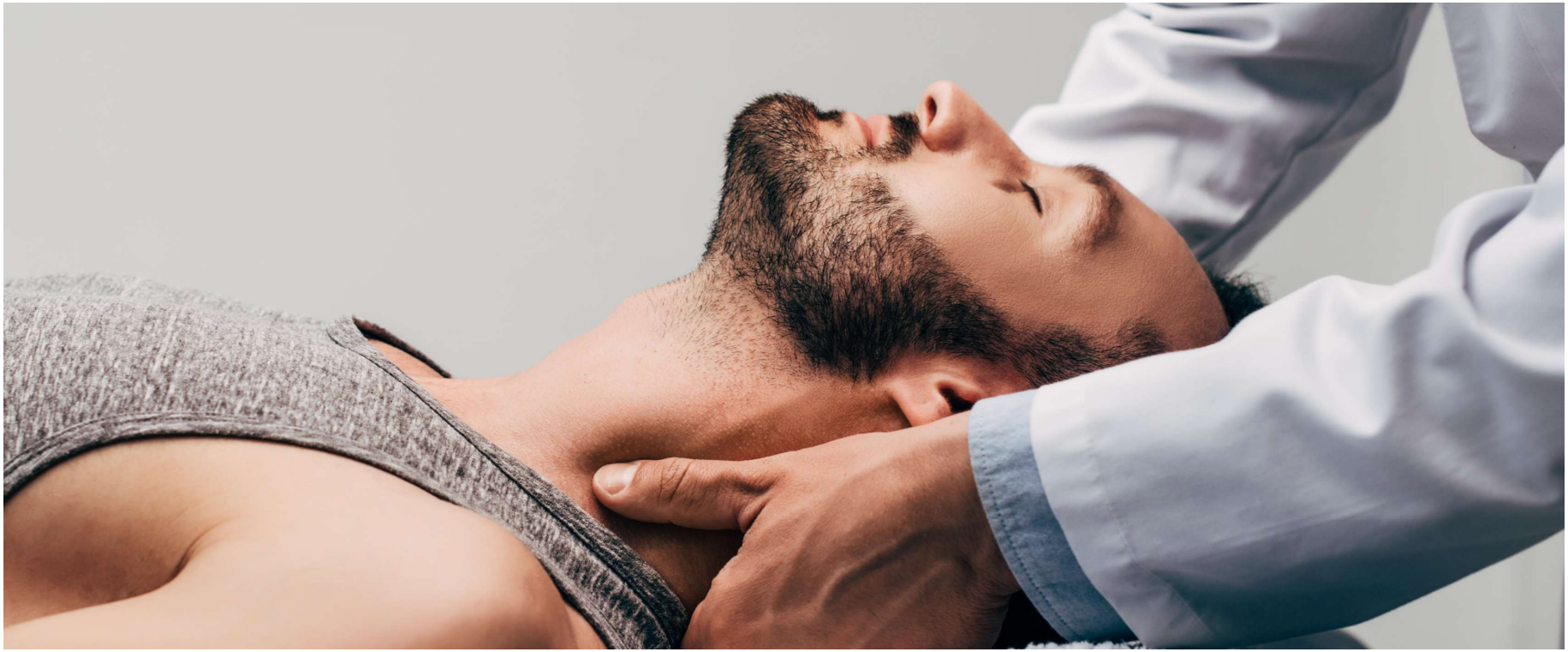
The “straights” defined chiropractic as focused on the analysis and correction of the vertebral subluxation to foster the fullest expression of the individual’s innate intelligence. [1]

Mixer chiropractors "mix" diagnostic and treatment approaches from chiropractic, medical or osteopathic viewpoints. Unlike straight chiropractors, mixers believe subluxation is one of many causes of disease, and hence they tend to be more open to mainstream medicine.

SPECIALTY PRACTICES

- DC's who have specialized training may set up specialty practices and focus on the patient population within their specialty. Examples would be Pediatrics, Neurology, Orthopedics, etc.
- DC's may integrate with other healthcare specialties. Some common configurations:
  - DC/PT
  - DC/Naturopath
  - DC/Acupuncturist
  - DC/MD – Usually a Nurse Practitioner or PA

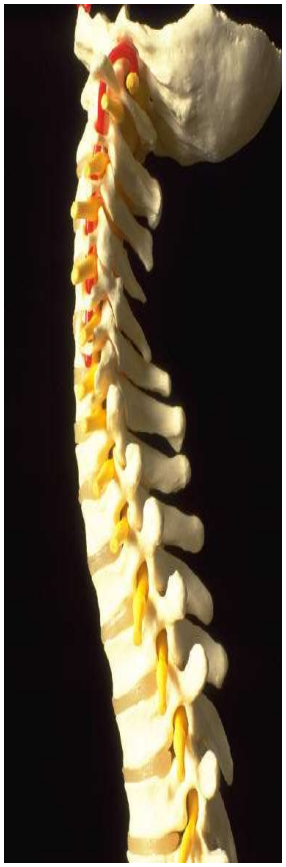
CHIROPRACTIC FAQ’S



In your job, patients will ask you questions. Do you know how to answer?

I know Chiropractors don't prescribe drugs and medicine, but what else makes them different?

The examination of the spine to evaluate structure and function is what makes chiropractic different from other health care procedures. Your spinal column is a series of movable bones which begin at the base of your skull and end in the center of your hips. Thirty-one pairs of spinal nerves extend down the spine from the brain and exit through a series of openings. The nerves leave the spine and form a complicated network which influences every living tissue in your body.



What causes poor spinal health?

Accidents, falls, stress, tension, overexertion, and countless other factors can result in a displacements or misalignments of the spinal column, causing irritation to spinal nerve roots. These irritations are often what cause malfunctions in the human body. Chiropractic teaches that reducing or eliminating this irritation to spinal nerves can cause your body to operate more efficiently and more comfortably.

Do Adjustments Hurt?

Under normal circumstances, adjustments don't hurt. The patient may experience a minor amount of discomfort during the adjustment which lasts only seconds.

Somebody told me Chiropractic Adjustments can cause a Stroke. Is that true?

- A review of the safety of chiropractic interventions published in 2009 found no robust data on the incidence of adverse reactions after chiropractic care. Estimates of the risk of serious adverse events such as stroke ranged from 0.05 to 1.46 per 10,000,000
- In populations of patients aged 66-99, this risk increases to .97 in 100,000 patients

SOURCE: National Library of Medicine https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4336806/

What is the “Popping” sound when an adjustment is Performed?

Many people think the popping sound is the sound of bones or joints being set back in place. The “pop” one hears during adjustments is the sound of trapped gas bubbles in between the joints being released.

Why do patients have to come multiple times for adjustments?

When a misalignment exists, the body naturally compensates and "protects" itself by changes in the muscles, ligaments and tissue surrounding the misalignment. Adjustments need to be performed gently and gradually, with great precision, to allow the vertebrae AND the surrounding muscles, tissues and ligaments to "memorize" their correct positioning.

EXAMPLES: Exercise program, orthodontics

Besides Adjustments, what other types of treatment do patients receive?

Many DC's use a combination of passive therapy, rehab or exercise instruction, natural vitamin/nutrition supplements, supports, massage, and dietary counseling in their practices to help the healing process and assist patients with behavioral changes necessary to accomplish more permanent results to their healthcare.

Why do Some Patients Feel Discomfort or Pain after an Adjustment?

Adjustments are performed in some cases, to reduce pressure on nerves. If a nerve is pinched, and has resulted in loss of sensation to an area of the body, restoring that sensation may initially be more uncomfortable that no feeling at all.

In some cases adjustments will create minor stress on muscles as they "re-learn" their correct position. Just like someone who exercises for the first time in a while.

When Patients are out of pain, why do they still need treatment?

It is the goal of all DC's to first eliminate pain and discomfort. Most DC's accomplish this fairly quickly by reducing pressure on the nerves, joints and ligaments. Once the patient is out of pain the real work of restoring normal function and strengthening the areas of weakness will take place. The patient may be out of pain, but the affected area is still unstable and weak or may need time to repair itself.

EXAMPLE: Root Canal!

What is the purpose of Maintenance or Supportive Care?

Many factors contribute to spinal misalignments or weaknesses. Stress, overexertion, improper bending/lifting, slips, falls, accidents, repetitive motion, improper sleep positions are some of those outside factors which Chiropractors CANNOT control. Periodic adjustments attempt to catch these new abnormalities before they become acute, and before they begin to do damage to the spine. It is more cost effective for the patient as well.

EXAMPLE: Preventative Dentistry

BECOMING A **C**HIROPRACTIC **A**MBASSADOR

- Learn the basics of Chiropractic
- Become a Chiropractic Patient
- Get your family under Chiropractic Care
- Understand YOUR Doctor’s Chiropractic Philosophy
- Talk to Patients about the great benefits of Chiropractic
- Give your Chiropractic Testimony
- Ask your Doctor to give you examples of Chiropractic Miracles

A Day In a Chiropractic Office

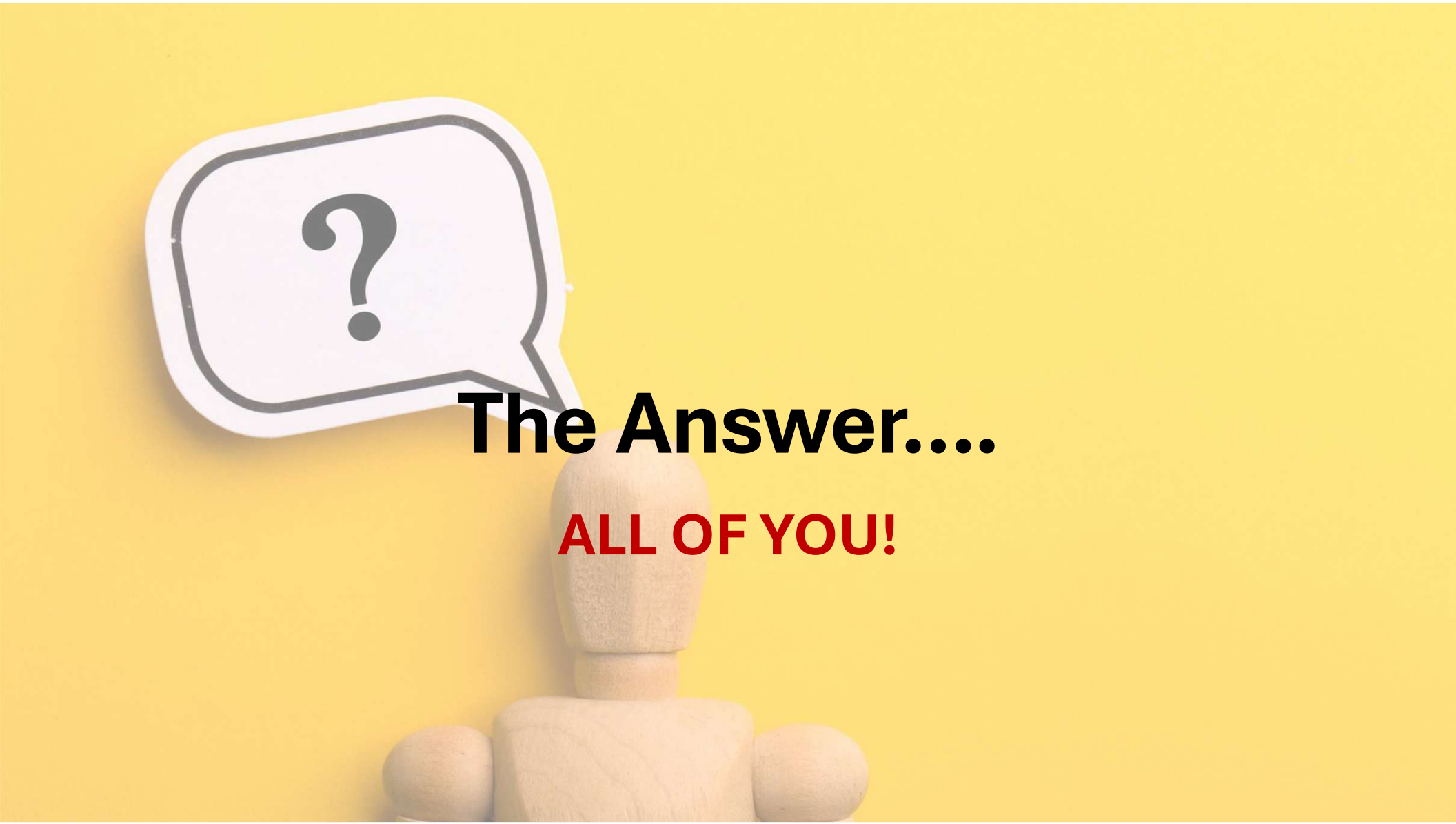
goldstarmedical.net 866-942-5655 info@goldstarmedical.net

The Moving Parts

The Provider(s)	• Patient Care/Patient Education
The CT’s/MA’s	• Patient Care/Patient Education
The Front Office CA	• Manage Time and Revenue
The Billing Department	• Revenue
The Ancillaries	• Massage Therapy/Acup/Nutrition
The Office Manager	• Compliance/Regulation

Whose Job is It?

Which Position is responsible for patient satisfaction?
Which Position is responsible for patient compliance?
Which Position is responsible for patient revenue?
Which Position is responsible for insurance revenue?
Which Position is responsible for preventing staff burnout?


The Answer....
ALL OF YOU!

Patient Satisfaction

The Provider(s)	• Excellent Patient Care, Authority, On Time
The CT's/MA's	• Support DC Tx Plans, Pt Care, On Time
The Front Office CA	• Efficient Scheduling, OTC Collections
The Billing Department	• Paid Claims
The Ancillaries	• Value Added Services
The Office Manager	• Running a tight ship

Patient Compliance

The Provider(s)	• Evaluate, Treat, Educate
The CT's/MA's	• Keep patients engaged, committed to tx
The Front Office CA	• Appts within 24, pay the bill
The Billing Department	• Unpaid claims lead to cancellations

Patient and the Revenue Connection

The Provider(s)	• Don’t treat patients based on insurance, don’t make deals. Focus on their health, not their wallet
The CT’s/MA’s	• Ensure patients are not skipping therapies/ancillaries
The Front Office CA	• OTC Collections/Patient Profiling/COB
The Billing Department	• Less than 45 days in AR/timely and accurate claims

The Perfect Day

1

Have your provider describe what a **perfect day** of treating patients would look like for them

2

Use it as a model for scheduling, traffic control, check in and check out procedures, building admin time

3

Review periodically to see if you are meeting the expectations, or if their idea of a Perfect Day has changed

TERMINOLOGY

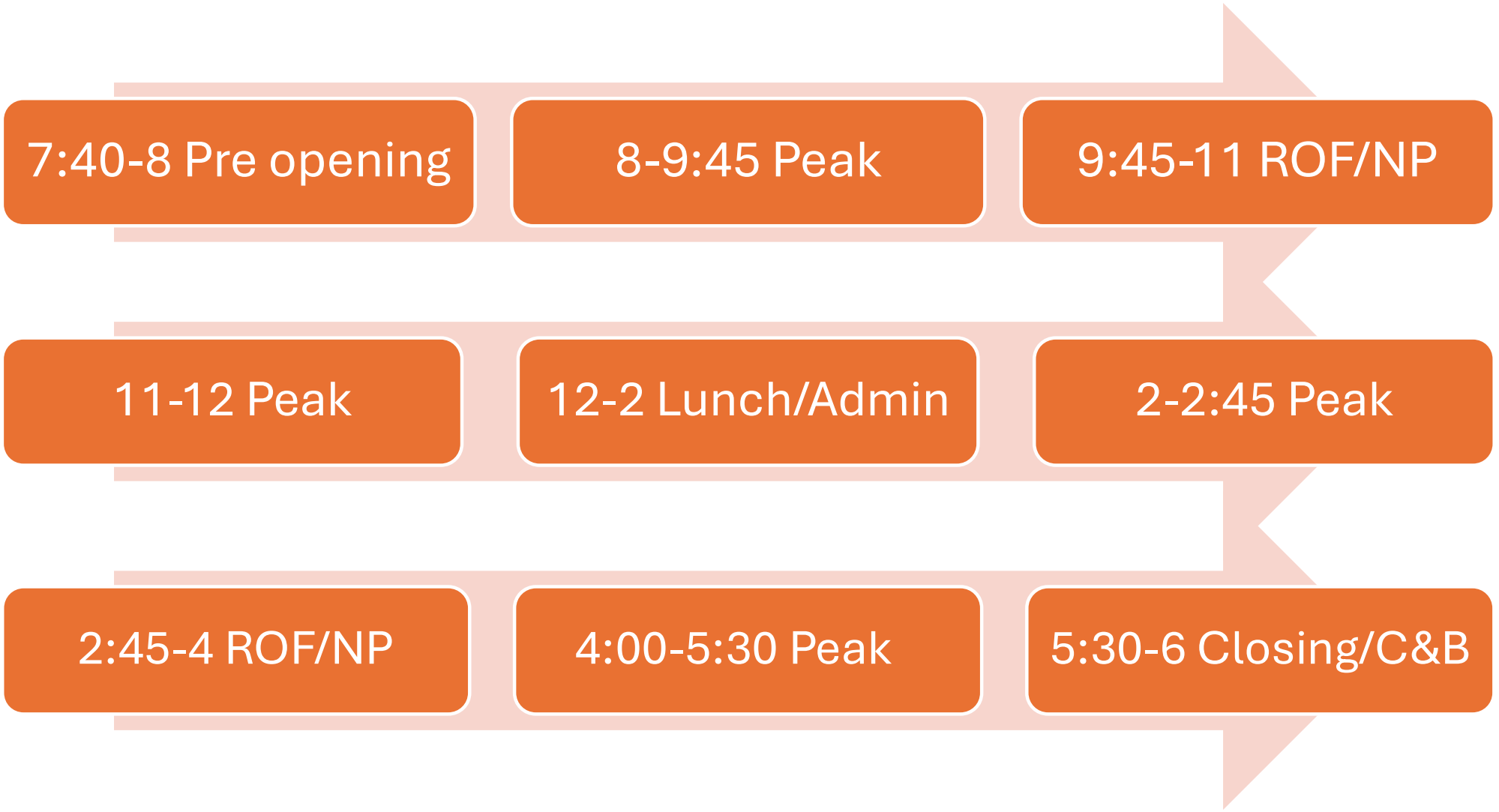
PEAK – During the day, peak times are when providers are only adjusting patients. No NP's, ROF's etc.

ROF – Report of Findings/Consultations

NP – New Patient

C&B – Checks and Balances

SAMPLE PERFECT DAY TIMELINE


7:40-8 Pre opening
8-9:45 Peak
9:45-11 ROF/NP
11-12 Peak
12-2 Lunch/Admin
2-2:45 Peak
2:45-4 ROF/NP
4:00-5:30 Peak
5:30-6 Closing/C&B

IMPLEMENTING THE PERFECT DAY

- Set a goal – can usually accomplish in 30 days
- Set up appointment book with blocks for Peak, NP, ROF, Admin, etc
- No need to reschedule everyone!
- Start using blocks for future appointments
- The blocks are a guide, not a law
- Policies and procedures are set up to handle the MAJORITY of situations in your office. Handle exceptions on a case by case basis

FROM OPENING TO CLOSING

- **Morning (pre-opening)**
  - Day starts at least 15-20 minutes BEFORE you start seeing patients
  - 10 min Shift Huddle – Each department reviews their day (based on the appointment book) so everyone knows what's going on. May need a shift huddle after lunch if you have part timers.
  - Are there any issues one department needs to share with the other?
    - Example: Ins dept looks at appt book and sees a patient whose insurance has termed. Alert front desk to get a new card, or collect from patient that day.
  - DC/Clinical: Review charts/tx plans. Are ROF's ready for financials? Any communication with back office needed?
  - Back office/CT- Equipment cleaned, working, inventory, supply review
  - Front desk – Any possible bottlenecks? Special circumstances? (Dr has to leave early)

Does your office have a pre-opening protocol?

PATIENT CARE HOURS: STAFF ROLES

Front Desk CA

Check in/Check out

Verify Patient Demographics (are they current?)

Update Insurance Info/Verify Coverage

OTC Collections

Manage Traffic (coordinate with back office)

Keeping Providers on Time/Focused

Answer, Screen, Route Phone Calls

Back Office (CT/Rehab Tech)

Assist with New Patient Intake (pre-consult, review patient history, record vitals)

Manage Traffic

Assist with Therapy/Rehab, other Ancillaries

Review Treatment plan, make sure Patients receive all the care prescribed

Patient Education

Xray Tech (if certified, if applicable)

PATIENT CARE HOURS: STAFF ROLES

Providers

- Exams/Xray (if applicable)
- Consults/ROF
- Treat Patients
- Review Plan Of Care, make adjustments if needed
- Coordinate care with CT and/or other Providers

Billing Department CA

- Make sure FD CA knows what to collect OTC for patients scheduled that day
- Update Insurance Info/Verify coverage
- If Prior Auth needed for a patient that day, make sure it's been obtained, communicate with FD if reschedule is required
- Are patient financial demographics current?

PATIENT CARE HOURS: STAFF ROLES

- **Office Manager**
  - Help out where needed
  - Cover Staff breaks
  - Keeping everyone on task, focused on patient care
  - Engage with Patients
  - Monitor HIPAA Compliance
  - Handle Patient Complaints

Does each staff member know their role during patient care hours?

FROM OPENING TO CLOSING

- **End of day**
  - Checks and Balances
  - “When the day is over, the day is over”
    - Appointments reconciled
    - Money reconciled
    - SOAP Notes completed
    - Product inventory completed
    - Equipment cleaned, ready for next day
  - Cyber and Office Security
    - All programs logged off
    - Supplies Secured
    - Paper Documents containing PHI secured/shredded

CHECKS AND BALANCES

- Know what EOD reports to run
  - Day Sheet – A report that shows all patient appointments, services rendered and payments posted that day
    - Give to Providers/CT's to review charges
    - Give to Billing Dept to review posted insurance collections
    - Give to FD to review posted OTC payments, compare against appointment book
  - Collection report
    - Do cash/checks taken OTC show up on Day Sheet?
    - CC Batch Reports – all CC payments posted to patient account?
- The shift ends when the employee completes their own EOD tasks

FROM OPENING TO CLOSING:

CHECKLIST

- Are we staying on time?
- Are the treatment rooms/adjusting tables full?
- Any monkey wrenches? Share with the team!
- Are the providers staying focused on patient care?
- Are the staff staying healthy and hydrated?
- Are patients happy and calm?
- Is there too much down time between patients?
- Do we have consistent end of day procedures?
- De we have Checks and Balances?


IMPROVING EFFICIENCY

Accountability – Who Is Responsible?

- ✓ Make sure everyone knows their roles during the different times of the day
- ✓ Have at least one person cross trained in each position
- ✓ Each person should be able to answer questions about their own duties and responsibilities
- ✓ Avoid Admin

Things to avoid during patient hours

- Non-Clinical Discussions with each other and patients
  - We can get very friendly with our patients as we get to know them. But they are here for treatment, not social conversation.
  - Avoid “water cooler” conversations amongst employees. Schedule a time for this, go to lunch together, or come in a little earlier so you all can chat about your kids, Netflix Top 10, etc.
- Instructions and Reprimands
  - Clinic time is NOT the time to discuss why the Front Desk CA double booked a new patient. Deal with it, notate the issue and discuss in a private meeting or staff meeting after clinic hours are over.

Things to avoid during patient hours

- SOCIAL MEDIA
  - Stay off SM platforms unless you are the admin of the clinic's Instagram or Facebook page.
  - Very high risk for Cyber Attack
- PERSONAL ACTIVITIES
  - Texting/Personal Calls
  - Social Media
  - Online Shopping

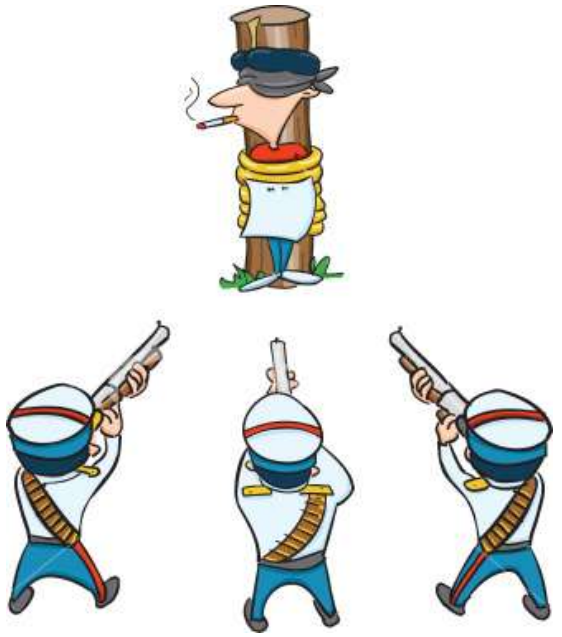
Does your office have a written personal cell phone use and social media policy?

Things to avoid during patient hours

- Admin and Paperwork…. wait….what??
  - We have to do admin work! There is always paperwork!
  - Try to build admin time into the day through block scheduling
  - During “peak” times of patient care, no admin work, all hands on deck
  - Consider setting admin only hours (1/2 day a week)
  - Never be too busy with admin to care for the patient.
- Providers having challenges completing their SOAP notes
  - Give them time when block scheduling
  - Use technology to improve documentation efficiency
  - Consider a scribe

Things to avoid during patient hours

- Interruptions
  - Taking a non-emergent phone call in the middle of patient care
  - Asking insurance department to talk to a patient who is in the office RIGHT NOW about their unpaid insurance *claims*
  - CT Asking Front Desk CA to “real quick” put a patient on E-Stim
  - Dr asking CA or Office Manager to run a quick errand for them
- Just enough time in between patients to get nothing done. Like scheduling a patient every 15 min when the doctor only needs 5.



EFFECTIVE PATIENT COMMUNICATION

WHAT ARE THE FOUR THINGS???

- A consistent Method for patient communication and compliance
- Can be followed by every staff person
- Guides Conversations/Eliminates Fluff
- These FOUR THINGS should be addressed in the proper order EACH TIME you engage with a patient

The Four things every patient wants to know

1. What's wrong with me?
2. Can you help me?
3. How Long is this going to take?
4. How much is this going to cost?

Using the Four Things at the Front Desk

Scenario: patient calls in for an appointment. First thing they say is… “Do you take my insurance?” They are asking you question #4 (How much is this going to cost?)

1. I’d be happy to answer that, but first, tell me, **what’s going on**? Are you in pain? Have you injured yourself?
2. Oh wow, I’m sorry to hear that…good news, I believe **we can help you**!
3. Let’s get you **scheduled for an appointment**, would morning or afternoon be best?
4. Now about **your insurance**…..

The Four Things CT Convo…

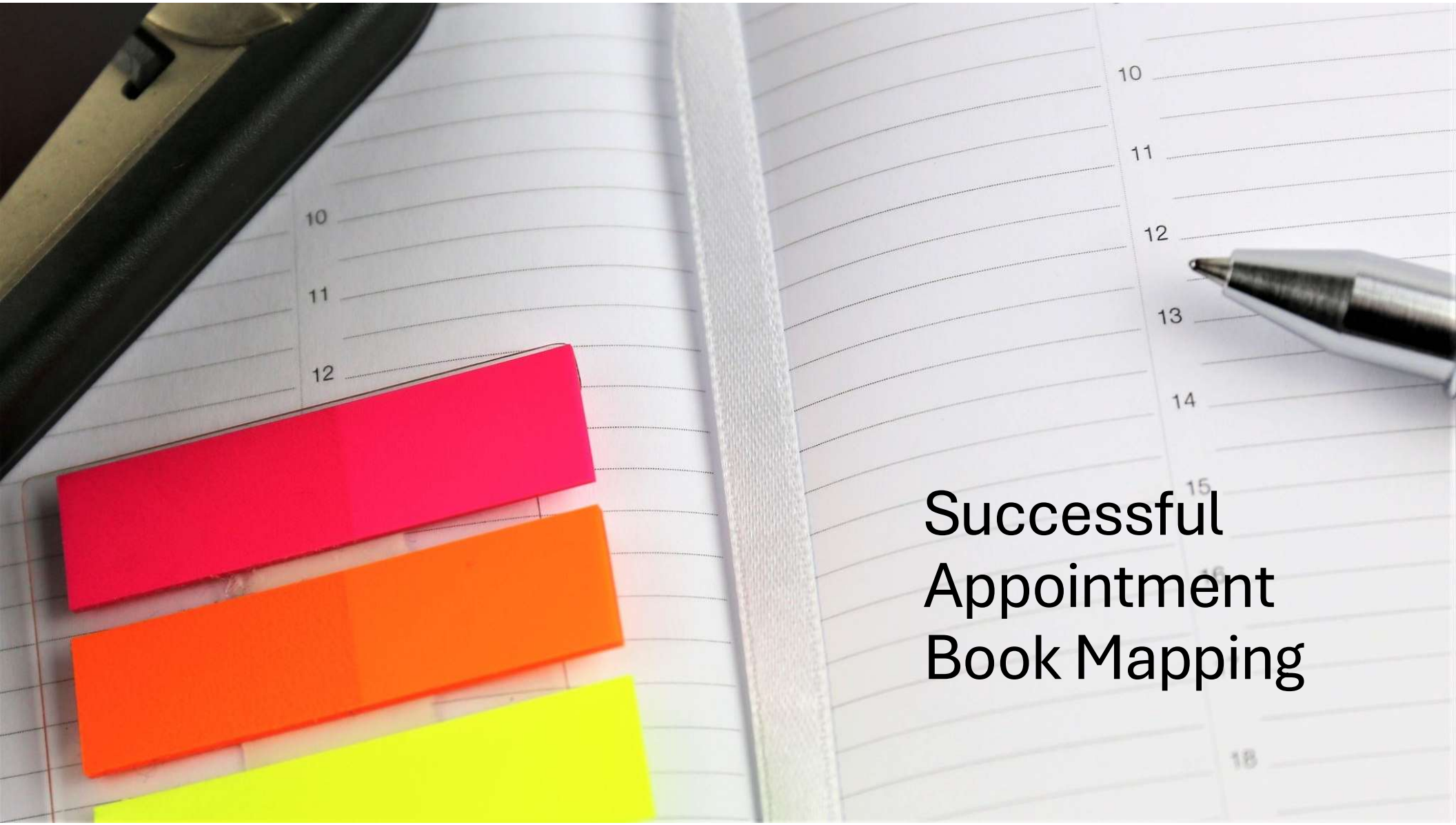
1. Joe, happy to see you! **How's that low back doing**…you seem to be walking better
2. **So glad your treatment is working**. Did you know that Chiropractic is effective in treating headaches/migraines? Do you ever get those? Do you know someone who does?
3. Let's make sure you keep that progress going. Looks like **you have xx more treatment and therapy sessions**. It's important to keep to your schedule for the best therapeutic outcome
4. **Money talk?/**Scheduling Issues?….refer to front desk or insurance department**. If it comes up.**

The Appointment Book

Navigating the Day

The Appointment Book – A Powerful Practice Management Tool

- The Front Desk CA is the Gatekeeper to a Well-Run Day in a Chiropractic Office
- The Appointment Book is the Primary Tool to Facilitate this Goal
  - Scheduling/Rescheduling Patients
  - Managing Provider Time
  - Managing Ancillary Staff
  - Managing Room Resources


Successful
Appointment
Book Mapping

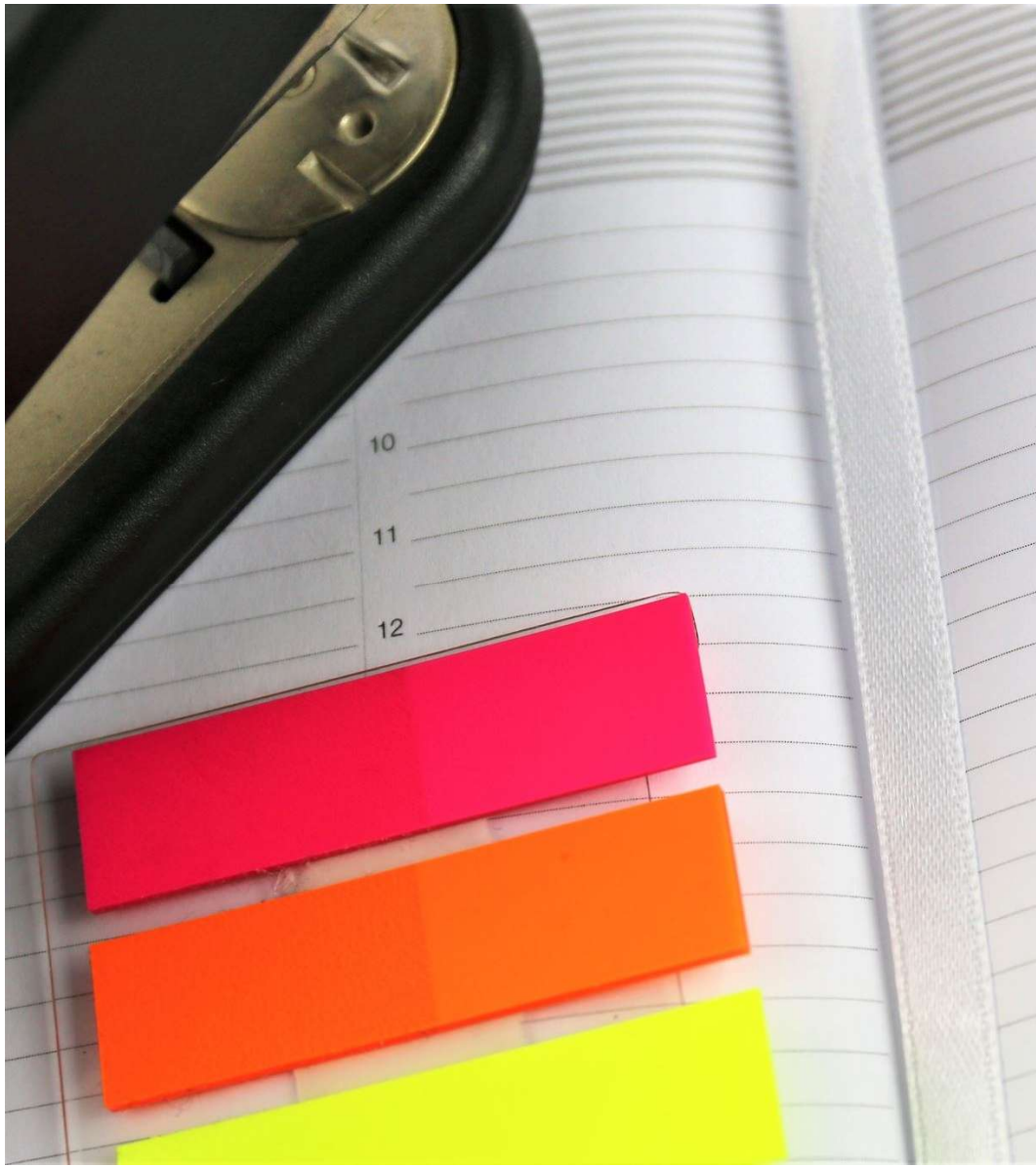
THE PERFECT DAY

Ask your doctor to describe a “perfect day” in practice

Draw your map based on the perfect day

Block Scheduling vs. Cluster Booking

- Cluster Booking schedules Patients back to back
- Block Scheduling schedules TYPES of Patients back to back



Block Scheduling Essentials

- Fill a block from the top of the hour down and bottom of the hour up
- Cancellations stay on the book (documents patient non-compliance)
- Don’t let the exception become the RULE (ex: Scheduling est pt in NP block or vice versa)

SCHEDULING PHILOSOPHY

- It’s YOUR BOOK
- YOU CONTROL the Traffic
- Keep EVERYONE Focused and Busy!
- Patients WILL COME when YOU tell them to come!
- Every Patient should have a NEXT APPOINTMENT
- YOU CAN DO THIS!!!!!

AUTOMATED APPOINTMENT SCHEDULER CHALLENGES

- If you use an Automated Appointment Scheduler through a Patient Portal or other Companion App (ie: Calendly), be sure to “block schedule” different types of appointments.
- Check for unused slots each morning, and open them up to same day call ins
- OR use unused slots for Admin time

PHONE PROCEDURES

- NEVER, NEVER, NEVER ask a patient “When would you like to come in” or “What would be a good time for YOU?”
- ALWAYS use 2 Choice technique; “Would you PREFER morning or afternoon”, or “I have 10 or 2, which would you prefer”
- If patient wants specific time: “Let me see what I can do…” “I’d love to, HOWEVER…” “Any other day would not be a problem”
- If patient INSISTS, then accommodate but let them know the situation (long wait, etc)
- Always get contact number for NP, and last thing your say is “OK, we’ll see you at….”

Multiple Appointment Scheduling

- NUMBER ONE method of reducing bottlenecks at front desk
- NUMBER ONE method of reducing cancellations
- NUMBER ONE method of preventing patients from falling through the cracks
- MAS anyone on a treatment plan

STANDING APPOINTMENTS

- Long term MAS –Helps build maintenance practice (Use for Self Pay patients only)
- Same time each month
- Reward for Patient who completes treatment plan - permanent reservation!
- Reward Loyal Patients. Review history of appointments and offer them the standing appointment
  - Reminder the day before
  - Gives them FIRST choice of the BEST appointments-rewards their loyalty to the doctor

ESCORTING/MOVING PATIENTS

- If front desk is blind to treatment area, back office needs to move patients
- Have rooms numbered or labeled
- Consider using a “jump seat” (Secondary Reception Area)
- Fill adjusting rooms, then jump seat; feed rooms from jump seat area
- Only escort new patients, by visit 3-4 patients should be able to move through the clinic themselves
- 2 minute 10 minute rule

The 2-10 Rule

- A patient should wait in the reception area a MINIMUM of 2 Minutes and a MAXIMUM of 10 Minutes
- Don’t just “Breeze” a patient back to the treatment area as soon as they walk in the door. Give them a chance to relax for a few minutes before sending them back to the treatment area
- A patient should never go without SOME contact for more than 10 minutes
  - New Patient should never wait more than 10 minutes to be taken back to consultation
  - New Patient should never wait more than 10 minutes in the consultation/exam room
  - Don’t have them waiting on the adjusting table more than 10 min
  - Unattended Therapies/Decomp – Check on Patient at least once every 10 min

HANDLING TRAFFIC JAMS

- THE EARLY (or LATE) PATIENT
  - DO NOT get out of sequence!
  - If doctor is doing admin, let him/her finish
  - Staff Meeting- put sign on door or at the front desk

HANDLING TRAFFIC JAMS

- THE EARLY PATIENT SCRIPT
  - Mr. Jones, GREAT to see you! I did have you scheduled at 9 and it's only 8:30. We do have ___ patients scheduled in the next 30 minutes. You are welcome to wait. Would you like a bottled water or some juice?
- THE LATE PATIENT SCRIPT
  - Mr. Jones, GREAT to see you! I did have you scheduled at 11 and it's 11:30 We do have ___ patients scheduled right now, so the doctor will be with you as soon as he/she can. You are welcome to wait. Would you like.....?

HANDLING TRAFFIC JAMS

- THE WALK-IN PATIENT
  - DO NOT get out of sequence!

Mr. Jones, GREAT to see you! I didn't have you scheduled today, but we will be happy to work you in. We do have ___ patients scheduled in the next 30 minutes, or we can schedule you later today. Would you prefer to wait or reschedule for later? (If they wait).....Would you like a bottled water or some juice?

HANDLING TRAFFIC JAMS

- THE CHRONICALLY EARLY/LATE Patient
  - May indicate patient's lack of commitment
  - Find out what the problem is
  - Help the patient find a solution

  Mr. Smith, I noticed that you have been having trouble making your 11 am appointments. Is there any way I can assist you? You seem to prefer 11:30. I can change all your appointments to 11:30 if you'd like.

The front desk CA is at the front line of successful revenue cycle management

A basic understanding of insurance and rules for patient collections is necessary in order to ensure RCM success

TYPES OF HEALTH INSURANCE

GROUP HEALTH (employer OR group sponsored)

MARKETPLACE PLAN (individually purchased)

MEDICARE (over 65 yrs/individuals with disability)

MEDICAID (low income)

LIABILITY

- PERSONAL INJURY (AUTO)
- PERSONAL INJURY (HOME)
- BUSINSS LIABILITY

WORKMAN'S COMPENSATION (work injuries)

UNION/RETIREMENT PLANS

IMPORTANT DEFINITIONS

- **DEDUCTIBLE** – A DOLLAR AMOUNT THAT THE PATIENT MUST PAY FOR MEDICAL SERVICES **BEFORE** THE INSURANCE STARTS PAYING

IMPORTANT DEFINITIONS

- **CO-PAY** – A “FLAT RATE” DOLLAR AMOUNT THAT THE PATIENT MUST PAY FOR MEDICAL SERVICES AT EACH VISIT/ENCOUNTER

IMPORTANT DEFINITIONS

- **CO-INSURANCE** – A DOLLAR AMOUNT THAT THE PATIENT MUST PAY FOR MEDICAL SERVICES **BEFORE** THE INSURANCE STARTS PAYING. COINSURANCE IS BASED ON A PERCENTAGE OF THE COST OF THE SERVICE. ALSO KNOWN AS COST SHARE.

IMPORTANT DEFINITIONS

- **COMMERCIAL INSURANCE** – A TYPE OF INSURANCE THAT IS OFFERED AND ADMINISTERED BY PRIVATE ENTITIES, AKA PAYERS. COMMON EXAMPLES ARE BLUE CROSS, UNITED HEALTHCARE, AETNA, CIGNA, HUMANA (THE BIG 5)

IMPORTANT DEFINITIONS

- **MEDICARE–** Medicare is federal health insurance for anyone age 65 and older, and some people under 65 with certain disabilities or conditions (End Stage Renal Disease, ALS).

IMPORTANT DEFINITIONS

- **MEDICAID–** Medicaid is a joint federal and state program that provides health coverage for some people with limited income and resources.

IMPORTANT DEFINITIONS

- **MARKETPLACE PLANS–** The federal Health Insurance Marketplace, which is also called the "Marketplace" or "Exchange," is the website where individuals can browse various health care plans available under the Affordable Care Act, commonly known as "Obamacare," as well as compare them, and purchase health insurance.

IMPORTANT DEFINITIONS

- **WORKER'S COMPENSATION–** Workers' compensation is **insurance that provides cash benefits and/or medical care for workers who are injured or** become ill as a direct result of their job.

IMPORTANT DEFINITIONS

- **PERSONAL INJURY**– Type of claim/insurance designed to protect individuals if they are injured or harmed because of someone else's act or failure to act; or if the individual accidentally caused harm to themselves

IMPORTANT DEFINITIONS

- THIRD PARTY ADMINISTRATOR (TPA)
  - A Company Commercial Payers may partner with to accept, process and pay claims on behalf of that Payer.
  - The relationship between Payers and TPA’s is fairly common.

IMPORTANT DEFINITIONS

- FISCAL INTERMEDIARY (FI)
- MEDICARE ADMINISTRATIVE CONTRACTOR (MAC)
  - An FI/MAC is a commercial payer contracted by a federal or state agency to accept, process and pay claims on behalf of that agency.

Successful RCM Starts at the Front Desk

- Patient Profiling
- Verification of Benefits
- Prior Authorization
- ABNs
- OTC Collections

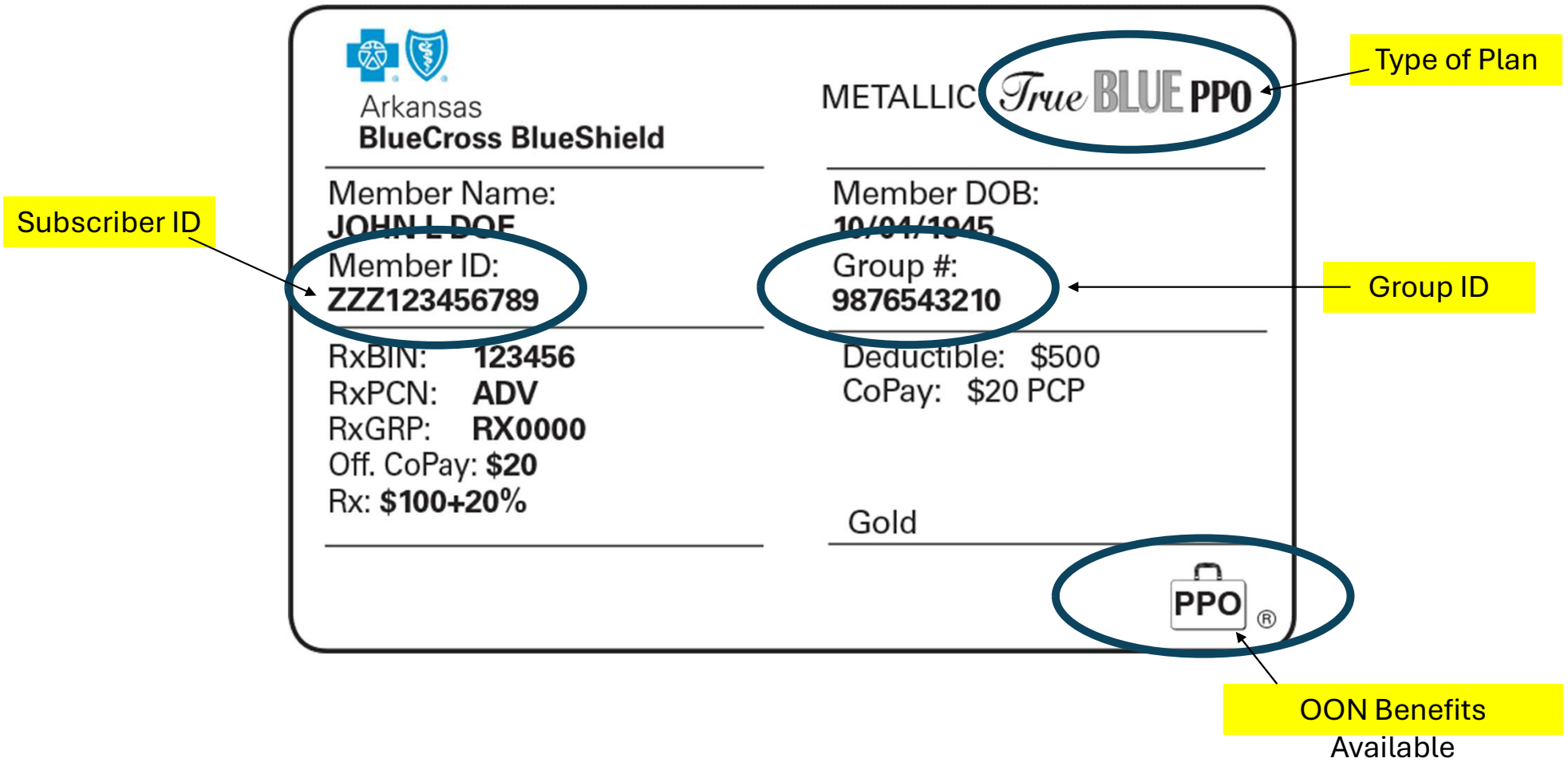
Patient profiling

- **Set up Patient in Software**
  - Personal Demographics – Name as it appears on insurance card!
  - Insurance Demographics –
    - Name/Payer ID of Ins Company
    - Subscriber ID/Group ID
    - Fee Schedule
    - Case Type
    - Primary/Billing Provider
    - Cost Shares
    - Limitations/Authorizations

ACCURACY COUNTS!
REMEMBER,
GARBAGE IN,
GARBAGE OUT!

What am I looking at?

HOW TO READ AN INSURANCE CARD


Arkansas
BlueCross BlueShield
METALLIC True BLUE PPO
Member Name:
JOHN L DOE
Member DOB:
10/04/1945
Member ID:
ZZZ123456789
Group #:
9876543210
RxBIN: 123456
RxPCN: ADV
RxGRP: RX0000
Off. CoPay: $20
Rx: $100+20%
Deductible: $500
CoPay: $20 PCP
Gold
PPO ®
Subscriber ID
Type of Plan
Group ID
OON Benefits Available

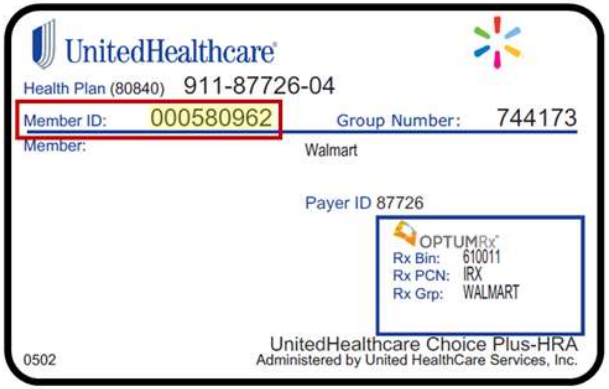
DON’T ASSUME EMPLOYER HAS THE SAME INSURANCE FOR EVERYONE!

Aetna Member ID Card

Arkansas Blue Cross Blue Shield Member ID Card

HealthSCOPE Benefits Member ID Card

United Healthcare Member ID Card



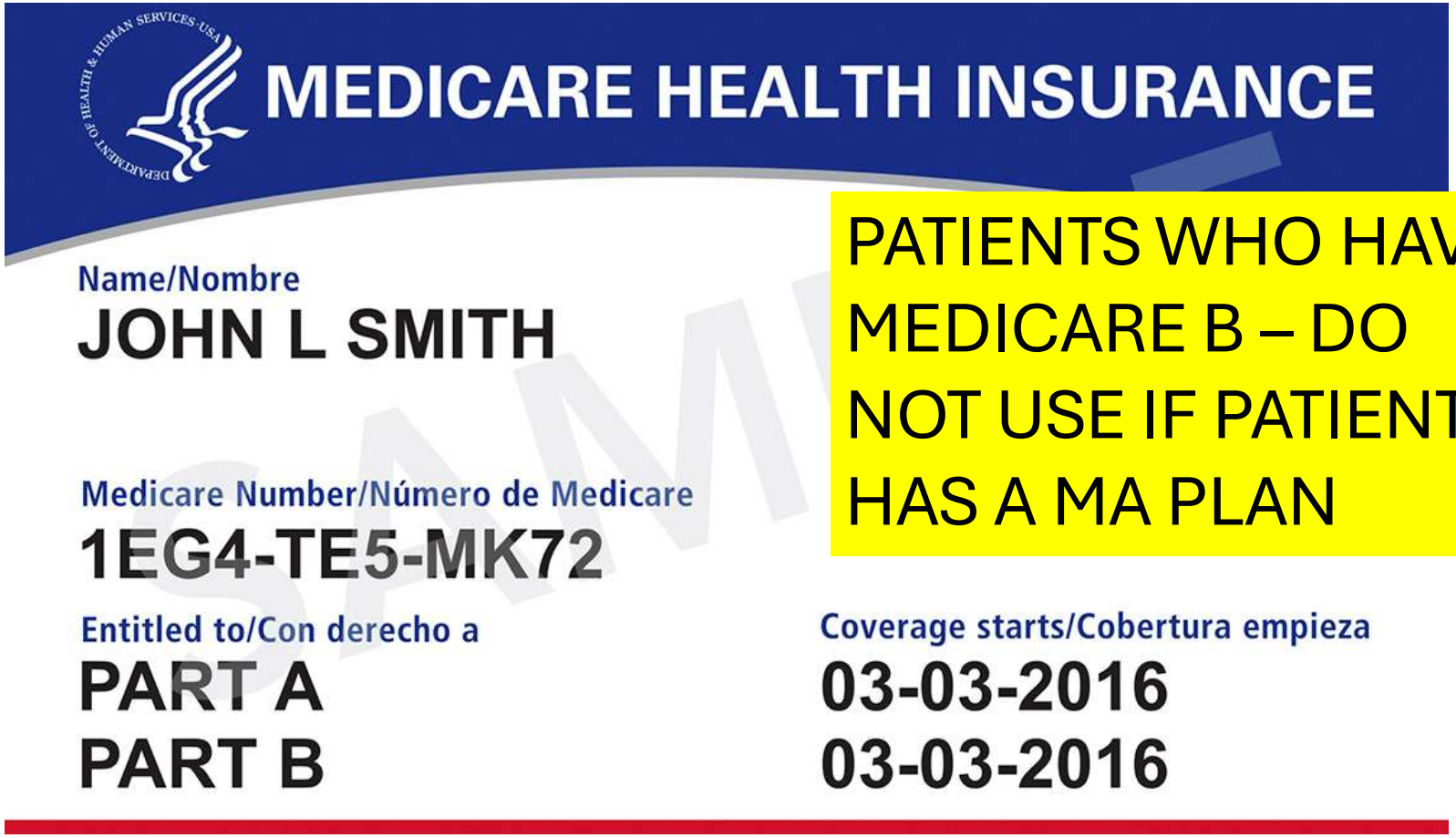
BACK OF CARD CONTAINS IMPORTANT INFO- COPY BOTH SIDES!

MEMBER NAME SHOULD BE ENTERED IN COMPUTER EXACTLY AS IT APPEARS ON THEIR INSURANCE CARD

ARE YOU IN NETWORK?

PAYER ID FOR E-CLAIMS

MAILING ADDRESS FOR PAPER CLAIMS


MEDICARE HEALTH INSURANCE
Name/Nombre
JOHN L SMITH
Medicare Number/Número de Medicare
1EG4-TE5-MK72
Entitled to/Con derecho a
PART A
PART B
Coverage starts/Cobertura empieza
03-03-2016
03-03-2016
PATIENTS WHO HAVE MEDICARE B – DO NOT USE IF PATIENT HAS A MA PLAN

This is a Medicare Supplemental Plan, aka Medigap

It is Supplemental to Medicare Part B

Plan "Letter" Determines Level of Payment

PLAN F

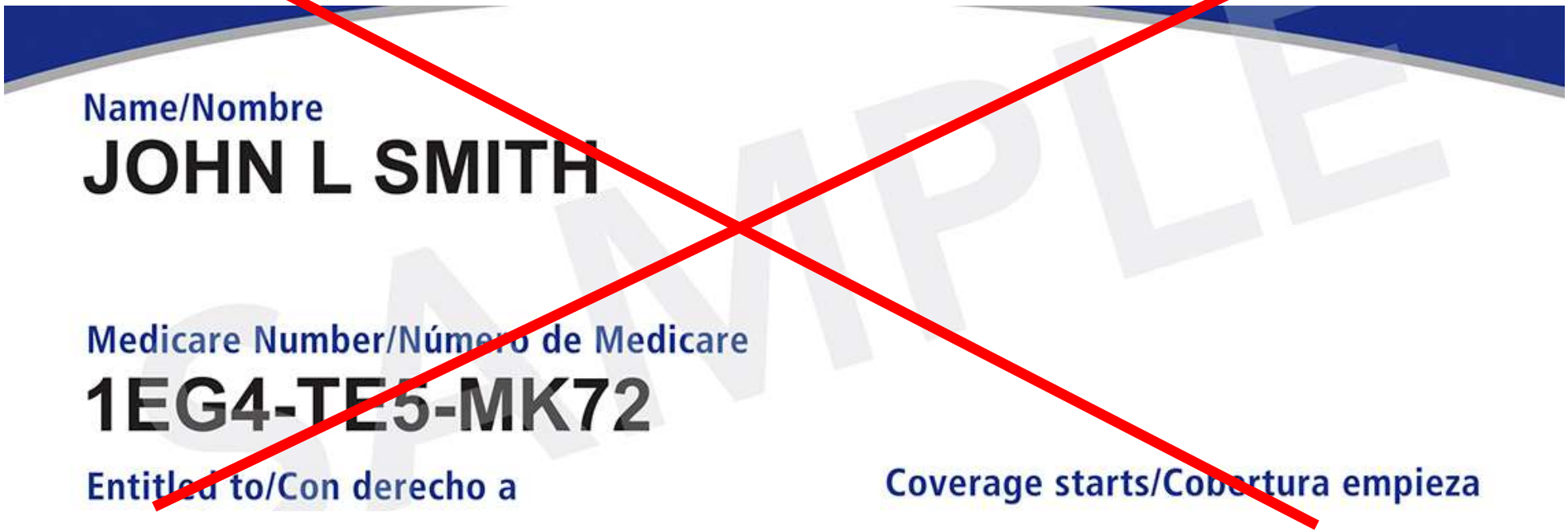
	Medigap plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2020**			
							$5,880	$2,940		

Supplemental Plans are designed to “gap” Medicare Coverage. If Medicare pays 80%, the supplemental plan takes care of the 20% at the rate indicated by the medigap plan.

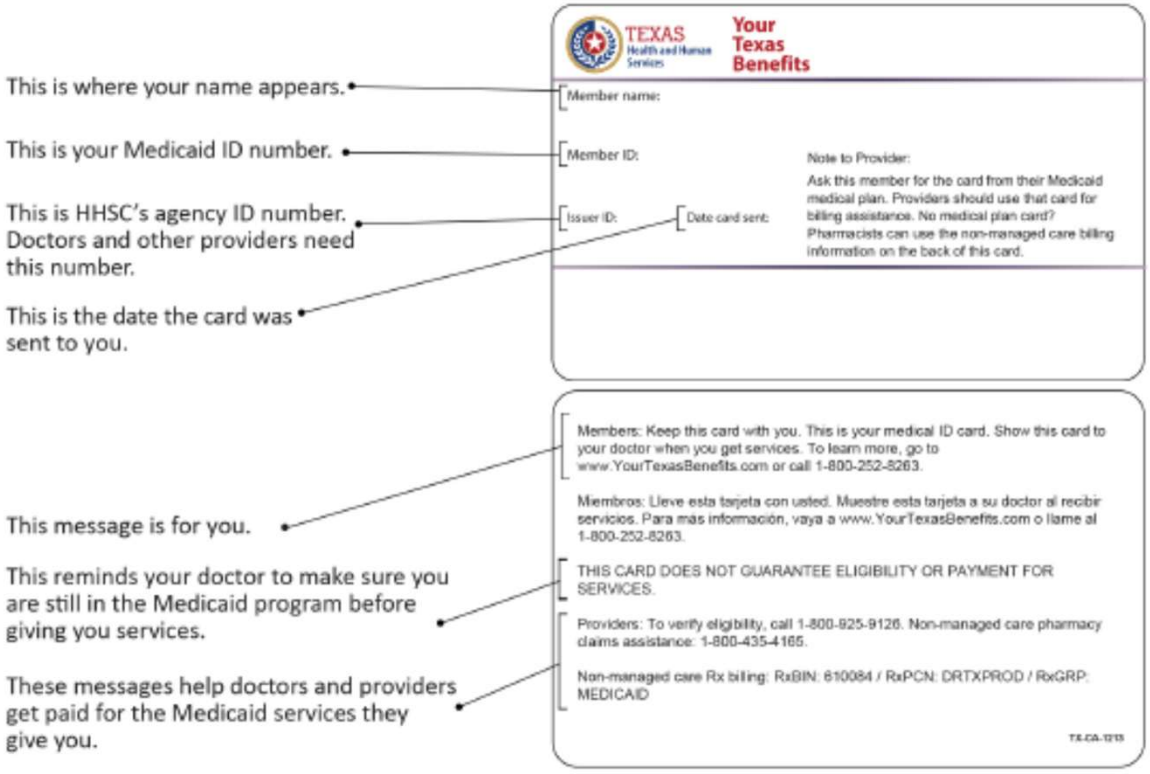
Most Medigap plans do NOT pay for services that Medicare does not cover.

Most Supplemental plans are “crossover” plans, and billing is not necessary. Medicare B forwards the claim info to the Medigap plan directly

IDENTIFYING MEDICARE ADVANTAGE PLANS



IF A PATIENT HAS A MEDICARE ADVANTAGE PLAN, DO NOT ENTER THIS CARD IN THE BILLING PROFILE- JUST KEEP A COPY ON FILE



SAMPLE MEDICAID CARD. MEDICAID PATIENTS NEED TO BE CHECKED FOR ELIGIBILITY MONTHLY!

WHEN A PATIENT HAS MORE THAN ONE INSURANCE PLAN

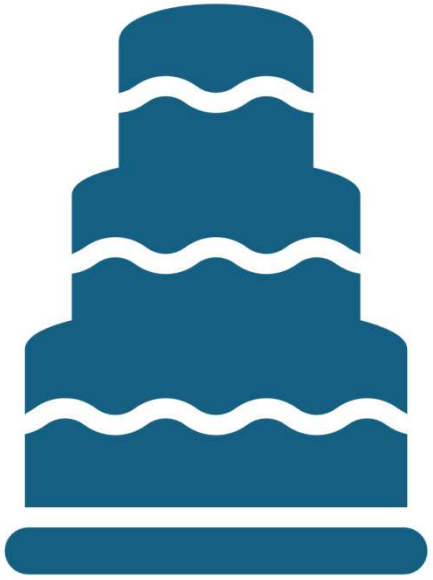
COORDINATION OF BENEFITS

COORDINATION OF BENEFITS COMMERCIAL PLANS

- **WHEN TWO RELATED PARTIES BOTH HAVE INSURANCE**
  - HUSBAND/WIFE
  - SAME SEX MARRIAGE
  - HUSBAND/WIFE/CHILDREN
- **IF BOTH SPOUSES HAVE COMMERCIAL INSURANCE, PATIENT'S IS PRIMARY, SPOUSE'S IS SECONDARY**

THE BIRTHDAY RULE

- **IF BOTH SPOUSES HAVE INSURANCE AND CHILD IS THE PATIENT, THE BIRTHDAY RULE USUALLY APPLIES**
- In the birthday rule, the health plan of the parent whose birthday comes first in the calendar year is designated as the primary plan
- Note that it doesn't matter which parent is older, because the year of birth is not a factor.



EXCEPTIONS

- **Same birthdays -** If both parents happen to have the same birthday, the plan that has covered a parent longer pays first.
- **Court Order** - Birthday rule does not apply to children whose parents have divorced or are members of a blended family. A court order about children's health coverage after a divorce supersedes all COB rules.
- **Blended Family** - If children live with a custodial parent and step parent, the custodial parent provides the primary insurance plan, regardless of whether the step parent's birthday comes first.
- **Divorce or separation** - When two or more plans cover your children as dependents when you're divorced or separated, the plan of the parent who has custody pays first. The plan of the new spouse of the parent with custody pays second. And finally, the plan of the parent who doesn't have custody pays last.
- **Group health and individual health plans -** If you and your ex-spouse have different types of health plans, the rules are also different. If you have a group health plan and your former spouse has an individual plan, the group plan pays first, regardless of the birthday rule.

WHEN IS MEDICARE PRIMARY?

- **When Does Medicare Pay First?**
  - Medicare B + Supplemental (Look for Plan letter, ie: Plan F, Plan K)
  - Medicare B or Medicare Advantage + Medicaid (called dual eligible)
  - Medicare Advantage + nothing (EXCEPT if patient is dual eligible)
  - Medicare B + Group Health (if employed and company has less than 20 employees)
  - Medicare B (SSDI) + Group Health (if employed or dependent and company has less than 100 employees)
  - Medicare B + Retirement Plan (if Medicare eligible and NOT employed)

WHEN IS MEDICARE SECONDARY?

- **When Does Medicare Pay Second?**
  - Group Health is Primary (if patient is employed and company has MORE than 20 employees)
  - Group Health is Primary for Medicare SSID (if patient is employed or a dependent and company has MORE than 100 employees)
  - Liability Claims (Auto/Injury)
  - Work Comp Claims

INSURANCE VERIFICATIONS

- WHY ARE INSURANCE VERIFICATIONS SO IMPORTANT?
  - Insurance reimbursements make up 30-50% of the doctor's total fee-for-service
  - The remainder is usually split between a contractual write off and a patient co-pay or coinsurance/ deductible.
  - If you don't know what to collect from the patient at the time of service, the doctor could lose up to 50% of their fee.
  - It's always easier and less costly to the doctor to collect from the patient at the time of service than to bill them later.

INSURANCE VERIFICATIONS

- CHECK BENEFITS ON ALL NEW PATIENTS
- CHECK BENEFITS ON ALL ESTABLISHED PATIENTS WHO HAVE NOT BEEN SEEN IN AT LEAST 3 MONTHS (do online eligibility check monthly)
- CHECK BENEFITS AT THE START OF EACH CALENDAR YEAR (CY).
- CHECK BENEFITS AT THE START OF EACH FISCAL YEAR (FY), IF THE PATIENT HAS A FISCAL POLICY
  - Example, School Teachers, college students: Many times their policies run from Sept 1 – Aug 31 rather than Jan 1 – Dec 31.

When prior auth is required….

- Check deadlines for PA's –How soon does PA need to be submitted? Can you get Retro PA?
- Use Online Resources to Submit PA's
- Most Chiropractic PA's are for certain numbers of visits over a certain period of time. Most Insurance Companies will give PA for a portion of the Treatment plan. Patient may need additional PA's. Develop a tracking method to follow patient's PA's.

WHERE TO GO…..

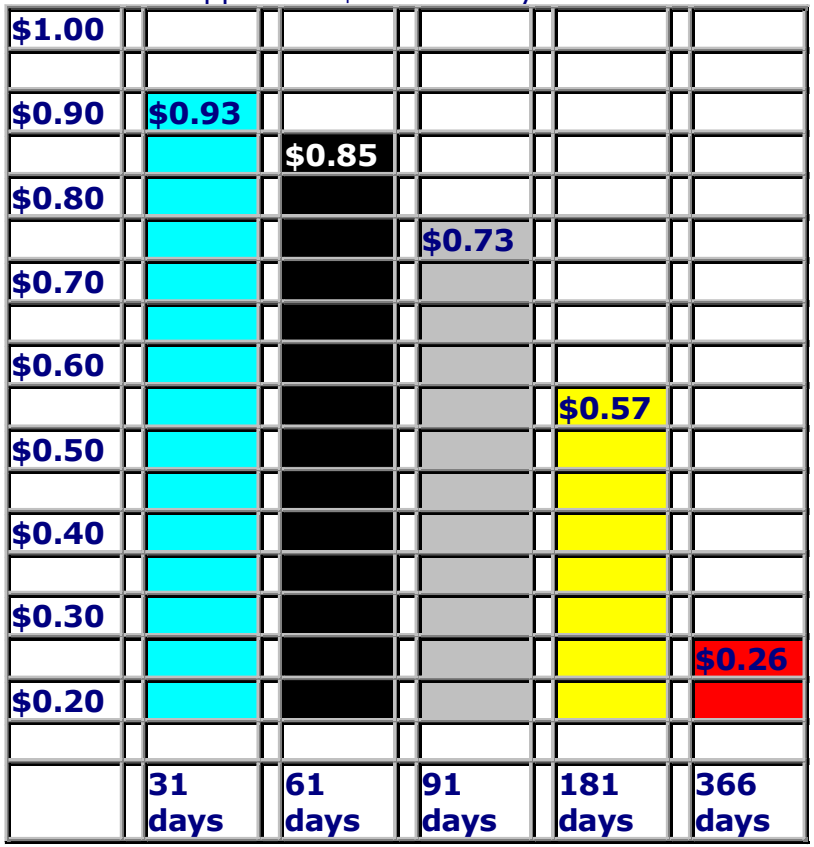
- ASHN- American Specialty Health Network
- Provider Inquiries (800) 972-4226
- M-F 5:00 a.m. – 6:00 p.m. PST
- www.ashlink.com

WHERE TO GO…..

- UNITED HEALTHCARE/OPTUM
  - Optum/ACN quick check 888-329-5182. Anytime you have a UHC patient needing chiropractic care, call this number first and key in the data requested to see if Optum preauth is necessary.
  - https://www.myoptumhealthphysicalhealth.com/


COMPLIANT PATIENT
COLLECTIONS

Look what happens to $1.00 when you don't collect it TODAY!



How Important are Timely Collections?

...Source: The Commercial Law League of America

After one year, the uncollected dollar you worked for is only worth 26 cents!

PATIENT COLLECTIONS

Represent approximately 65%-80% of all billed services (National Average)

If you ran a monthly collections report would 65% of your collections represent cash patients, insurance patient's non-covered (co-pay, co-insurance, deductible) amounts?

In first quarter of each year, this amount may go as high as 80-90% due to collection of deductibles.

NAVIGATING THE PATIENT COLLECTION MINEFIELDS

- Patient Collections is not a “one size fits all” process.
- Different types of patient revenue are subject to different rules and laws
  - Federal
  - State
  - Managed Care Contract

CA’S MUST BE AWARE OF THESE DIFFERENT RULES TO PREVENT NON-COMPLIANT COLLECTION PRACTICES

REVENUE CATEGORIES

- Co-Pay
- Deductible
- Coinsurance
- Non Covered Services (Not Covered under Insurance Plan, or Self Pay Patients)
- Contractual Obligations/UCR Differential

FEDERAL LAWS THAT REGULATE COLLECTION OF PATIENT BALANCES

- CMS/HHS: Medicare/Medicaid Rules on Inducements and Discrimination
  - Prohibition of Discounting Copay/Coinsurance and Deductibles
- AKS: Anti Kickback Statute – TOS Discounts/Dual Fee Schedules
- FCA: False Claims Act. Falsely collecting for a Government claim on services that have not yet been rendered
- STARK: Prohibits referrals to other entities in which the owners share profits
- NO SURPRISES ACT: Protects patients from receiving surprise medical bills (OON and CASH PATIENTS)

TOS DISCOUNTS
WHAT'S REASONABLE?

- The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. See section 1128B(b) of the Act. *(SOCIAL SECURITY ACT)* Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to **parties on both sides** of an impermissible "kickback" transaction. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
- The OIG (Office of Inspector General) issued an advisory indicating that **chiropractic TOS discounts should not exceed 8-15%** AND that discount must be directly tied to the "bookkeeping savings" that is allowed the practice by not having to submit claims, do follow-up, etc. This must be clearly defined within your Financial Policy so as to eliminate confusion and misunderstanding

https://oig.hhs.gov/documents/advisory-opinions/550/AO-08-03.pdf

Is a TOS Discount a Fee Schedule?

- When TOS is permitted in a state, keep in mind that your TOS fees are not a "fee schedule" but are actually a "bookkeeping savings" discount from your standard fees. This is why the percentage of discount must be defined and within OIG guidelines. The reason you are able to offer a TOS discount is because of the savings the practice is achieving by not having claims to file to carriers and waiting for processing and payment. This is also why, when they're applicable, TOS discounts are only allowed when payment is being collected at the time of service. Again, invoicing patients this discounted amount is not permitted — it must be collected as services are rendered.
- For eligible patients, practices are able to offer these discounts *because* it is being paid at the time-of-service and no claims submission, billing or waiting for payment applies. This means, for your eligible patients, if they say "bill me" or "I'll bring a check in next week", they are not eligible for the TOS discount.

https://oig.hhs.gov/documents/advisory-opinions/550/AO-08-03.pdf

HOW CAN WE OFFER DEEPER DISCOUNTS?

- Place your cash/self pay patients under a DMPO (Discount Medical Plan Organization)
  - DMPO will place your cash fees under a CONTRACT. You then have a contractual obligation to abide by the fee schedule.
  - DMPO must be licensed in your state
  - Look for flexibility. Do they tell you what the cash fee schedule will be, or can you customize it?
  - If your patient is signed up under a DMPO that you participate in, no further discounts are afforded to them.

CHIRO HEALTH USA

- **CHIRO HEALTH USA** – Largest DMPO in the Chiropractic Profession, over 50,000 providers nationwide
  - Custom Fee Schedules
  - Compliance Assistance
  - Patients Pay $49/annually for the entire family
  - CHUSA fees go back into supporting the Chiropractic Profession

MANAGED CARE CONTRACTS THAT REGULATE COLLECTION OF PATIENT BALANCES

- May have language prohibiting pre-pays of patient cost share
- Prohibits collections for claims that were never filed
- Prohibits collections on denied claims in which the provider did not adhere to the contract (ie: Failure to Obtain Prior Auth when PA was required)

DOCUMENT LIST FOR COMPLIANT COLLECTIONS

- **Written Financial Policy of Practice**
  - Easy to Understand Language
  - By Financial Class
  - Contains Necessary Rules per Federal and State Guidelines
  - Review with Patient VERBALLY, have them sign/date, and office witnesses
- Notice of OON Disclosure (No Surprises Act)
  - If you are OON with the patient's insurance plan, they must receive this prior to being seen

DOCUMENT LIST FOR COMPLIANT COLLECTIONS

- **Good Faith Estimate (No Surprises Act)**
  - If you are performing services not covered by insurance or individual is a full self-pay patient (no insurance)
  - Must be given to the patient prior to treatment. Most new patients will have several GFE's (Day 1, Active Care, Maintenance Care)
- **Written Treatment Plan from the Provider**
  - Cannot offer prepay packages without it
  - Cannot do a GFE without it
- **DMPO Agreement/Card – NOT RETROACTIVE!**
- **ABN'S**
- **WAIVER TO FILE INSURANCE**

_____CHIROPRACTIC/DR._____

Financial Policy of Clinic

Common Services (Not all services are listed here)	Fee/Fee Range
New Patient Examination	$40.00-$200.00
Established Patient Re-evaluation	$40.00-$150.00
Spinal Manipulation (1-2 regions)	$45.00
Spinal Manipulation (3-4 regions)	$55.00
Manipulation other than spine (hand, shoulder, foot, etc)	$35.00
Electrical Stimulation Therapy	$20.00
Traction/Roller Bed	$20.00
Therapeutic Exercise/Neuromuscular Reeducation, per 15 min	$45.00
Trigger Point Therapy, per 15 min	$45.00
Cervical (Neck) X-ray	$80.00-$150.00
Thoracic (Mid-Back) X-ray	$80.00-$150.00
Lumbar (Low-Back) X-ray	$80.00-$150.00
*Maintenance Visit	$45.00
*Acupuncture	
*Supports/Vitamins/Supplies	Priced as marked

*Not covered by insurance. All other services above may be covered by your insurance plan, depending on your policy.

_____**Patients with Insurance**: We will bill your insurance for services rendered in the office. We will check on your benefits as a courtesy to you; however an insurance companies' a quote of coverage is NOT a guarantee of benefits. **We will collect 100% of services not covered by your insurance carrier. If you have a copay, coinsurance or unmet deductible, you will be responsible for payment of your estimated out of pocket costs at time of service.** Please note that some patients' policies are written to where they may have to pay a deductible for certain services, and/or a copay for certain services. Insurance policies are a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits. If your policy prohibits collection of deductible and/or coinsurance prior to claim processing, we will require a credit/debit card to be kept on file. Payment for services not covered due to unmet deductible, coinsurance amount or policy exclusions will be automatically processed after receipt of Explanation of Benefits (EOB) from your insurance carrier. **Patient Initials ____ Staff Initials _____**

_____ **Medicare/Medicare Advantage Patients**: **Medicare Part B only covers manipulation of the spine**. All other services are not covered and will be your responsibility. Medicare does not pay for Maintenance care. **You will be required to meet your annual Part B deductible, which is currently $_____ and pay 20% of the allowed fee on the spinal manipulation, which is currently $_____, in additional to 100% of all non-covered services.** Supplemental/Medigap policies may cover the Part B deductible and the 20% coinsurance, but only for services allowed by Medicare. In the case of Chiropractic services, most Medicare supplemental/ Medigap plans will only cover the Medicare coinsurance for spinal manipulations. Supplemental/Medigap policies generally do not pay for services that Medicare does not allow. However there are some rare exceptions. In addition to this Financial Policy, Medicare patients will be required to sign an Advance Beneficiary Notice which will inform you of your billing options as a Medicare patient. Medicare Advantage plans generally follow the same guidelines as Medicare Part B, except you may have a co pay instead of a deductible/20% plan.

Patient Initials _____ Staff Initials_____

CLINIC FINANCIAL POLICY, CONT.

_____ **Personal Injury/Workman's Compensation**: Many Personal Injury and Workman's Compensation claims are covered 100%. However the bill is ultimately your responsibility. In order to facilitate a claim, you must provide our office with the documentation necessary to prove a valid claim, as well as the name(s) of any claims adjuster/attorney, etc handling the case, claim numbers and mailing address to send bills. Failure to provide the documentation needed will result in immediate conversion of your case to cash/self pay, and all payment will be due on receipt. If your case is turned over to an Attorney for final settlement, our office will wait up to 12 months for settlement to be completed. Should your settlement case exceed 12 months, you will be required to make monthly payments on your account until such time as the case settles. Should there be an unfavorable settlement on your case, you will be responsible for the balance due, with the exception of any negotiated settlement rates agreed upon by Rise Chiropractic and your Attorney. **Patient Initials _____ Staff Initials _____**

_____ **Patients without Insurance or Limited Benefits**. You will be required to pay for your services at the time they are rendered. You may be entitled to a discount off the billed fees, if you pay in full at the time of service. Your options will be explained to you when the doctor presents your treatment plan. **Patient Initials _____ Staff Initials _____**

_____**Payment Plans/Financial Hardship.** If payment at time of service is going to produce a financial hardship, we do offer, with an auto-pay option, a short term payment plan. Please discuss this option with our staff if you feel it is necessary to complete the care you need. We also have available discounts for patients who meet state and/or federal poverty guidelines or other special circumstances. Verification will be required to qualify for a financial hardship discount. **Patient Initials _____ Staff Initials _____**

_____**No STATEMENT POLICY**. Our office has a No Statement Policy. This means we do not send out balance due statements by mail. If you have a balance on your account that needs to be paid, you will.....(state process for receiving notification of bill). Upon notification, you will have the option to pay your bill online. Failure to pay bill in a timely manner (within 10 business days of notification) will result in your authorized credit card being debited automatically for the amount due.

____ I have read and understand the financial policy of _____. I also understand that if I have insurance, or a valid auto or workman's compensation claim, my carrier may pay for some to most of the charges listed above, but no benefits are guaranteed. I understand that I am ultimately financially responsible for all services not paid by insurance or other third party. Should there be a balance due at the end of my treatment plan, I will receive an invoice for the amount and pay it promptly, or contact the office to make payment arrangements.

Printed Name of Patient/Responsible Party _____

Signature of Patient/Responsible Party _____

Date Signed _____ Witness Signature _____

SAMPLE GOOD FAITH ESTIMATE

Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals

Below is an example of a good faith estimate form for uninsured (or self-pay) individuals who are expected to receive a bill for their care. This sample form highlights key information that is required by the No Surprises Act. Providers and facilities do not have to use this specific form, as long as they use a form that includes the required information. For a full list of good faith estimate requirements, see the regulatory requirements at 45 CFR § 149.610(c). To access the form, see the Good Faith Estimate for Health Care Items and Services template.

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

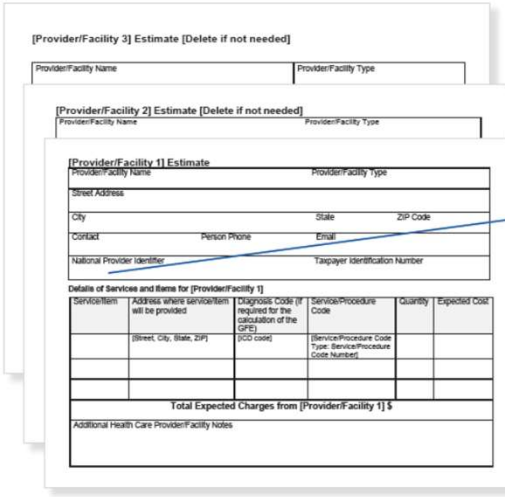
Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: ____/____/____		
Account Number (last four digits) (optional):		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail [ ] By email [ ] By phone		
Patient Diagnosis (if determined)		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	
If scheduled, list the date(s) the Primary Service or Item will be provided: [ ] Check this box if this service or item is not yet scheduled		

The form must include information such as the patient's name, date of birth, and the primary item or service (with diagnosis codes).

Revision Date: 8/2023

Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals



[Provider/Facility 3] Estimate [Delete if not needed]

Provider/Facility Name | Provider/Facility Type

[Provider/Facility 2] Estimate [Delete if not needed]

Provider/Facility Name | Provider/Facility Type

[Provider/Facility 1] Estimate

Provider/Facility Name | Provider/Facility Type

Street Address

City | State | ZIP Code

Contact | Person Phone | Email

National Provider Identifier | Taxpayer Identification Number

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code (if required for the calculation of the GFE)	Service/Procedure Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service/Procedure Code Type: Service/Procedure Code Number]		

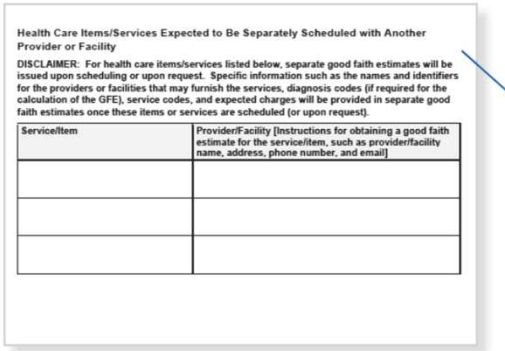
Total Expected Charges from [Provider/Facility 1] $

Additional Health Care Provider/Facility Notes

The good faith estimate must include a list of items or services that are reasonably expected to be furnished for the period of care.

This list must be grouped by provider. The No Surprises Act requires the estimate to describe the items and services that will be provided by the convening provider as well as items and services that will be provided by any co-providers or co-facilities.

However, the federal government currently is not enforcing the requirement for co-providers and co-facilities, so individuals may still receive an estimate that does not contain information from co-providers or co-facilities.



Health Care Items/Services Expected to Be Separately Scheduled with Another Provider or Facility

DISCLAIMER: For health care items/services listed below, separate good faith estimates will be issued upon scheduling or upon request. Specific information such as the names and identifiers for the providers or facilities that may furnish the services, diagnosis codes (if required for the calculation of the GFE), service codes, and expected charges will be provided in separate good faith estimates once these items or services are scheduled (or upon request).

Service/Item	Provider/Facility [Instructions for obtaining a good faith estimate for the service/item, such as provider/facility name, address, phone number, and email]

Good faith estimates must include a list of items or services that will require separate scheduling. These items or services are expected to be provided before or after the period of care for the primary item or service. For example, physical therapy following knee surgery.

https://www.cms.gov/files/document/nsa-sample-good-faith-estimate.pdf

Sample Good Faith Estimate for Uninsured (or Self-Pay) Individuals

Disclaimer
This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the Good Faith Estimate.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.

The good faith estimate must include a number of disclaimers. For example, it must state that the estimate is based on information known at the time it was created. Therefore, it won't include any costs for unanticipated items or services that are not reasonably expected and that could occur due to unforeseen events.

The good faith estimate must also explain that individuals have a right to initiate the Patient-Provider Dispute Resolution process if the billed charges from a provider or facility are $400 or more than the estimate from that provider or facility.

Individuals should keep any estimate provided in a safe place to compare with any bills received later, in case they wish to dispute a bill through the Patient-Provider Dispute Resolution process. For more information, see background information on what's a good faith estimate, examples of good faith estimates that do and don't qualify for the dispute process as well as the Decision Tree: Requirements for Good Faith Estimates for Uninsured (or Self-Pay) Individuals and the Decision Tree: Patient-Provider Dispute Resolution Process.

SAMPLE OON/NSA DISCLOSURE

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

The federal phone number for information and complaints is: 1-800-985-3059].

ABN’S

- ABN’S (ADVANCE BENEFICIARY NOTICES) are used to inform patients that certain services and procedures may not be covered, and they may be financially liable.
- ABN’s are used in all practice settings, with all types of insurance companies, including Medicare B, Medicare Advantage, and Commercial Payers.
- Failure to Notify patients in advance that a service might not be covered could result in the provider having to write off the entire claim, if not paid

MEDICARE PART B ABN

- You must issue an ABN:
- When an item or service is not reasonable and necessary under Medicare Program standards, including care that is:
    - Experimental and investigational or considered “research only”
    - Not indicated for diagnosis or treatment in this case
    - Not considered safe and effective
    - More than the number of services Medicare allows in a specific period for the corresponding diagnosis

- Excerpt from MLN: **ICN MLN909183 July 2020**

The MEDICARE PART B ABN

- ONLY MEDICARE PART B
- ONLY FOR SPINAL MANIPULATIONS
- OTHER SERVICES UNDER A VOLUNTARY ABN/NEMB
- USE THE MOST CURRENT FORM
- FILL OUT WHEN A PATIENT IS READY TO TRANSITION TO MAINTENANCE CARE
- NO LONGER NECESSARY TO FILL OUT ANNUALLY (AS OF OCT 15TH 2021)

Patient name:
Identification number: *(optional)*

Notifier name
Notifier address
Notifier phone (including TTY)

Advance Beneficiary Notice of Non-coverage (ABN)

Medicare doesn't pay for everything, even some care you or your health care provider think you need. **We expect Medicare may not pay for the item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

Item, test, service or care	Reason Medicare may not pay	Estimated cost
98940: 1-2 Region Spinal Manipulation **98941**: 3-4 Region Spinal Manipulation **98942**: 5 Region Manipulation	**Medicare only covers chiropractic treatment to correct a spinal misalignment (subluxation). Maintenance treatment is not a covered service.**	98940 - $40.00 98941 - $55.00 98942 - $70.00 (your fees here)

What to do now

- Read this notice to make an informed decision about your care.
- Ask any questions you have.
- Choose one option below to let us know if you still want to get the item, test, service or care.

Choose ONE option below. We can't choose for you.

If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

- ○ **Option 1: I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN).** You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.
- ○ **Option 2: I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.
- ○ **Option 3: I don't want the item, test, service or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay.

EXAMPLE OF A CHIROPRACTIC ABN (PAR PROVIDER)

DO NOT TELL THE PATIENT WHAT OPTION TO CHOOSE!

INSURANCE WAIVERS UNDER HIPAA/HITECH

- A patient has the right to request that the practice restrict the use and/or disclosure of PHI for treatment, payment and health care operations.
- On Feb. 18, 2010, the HITECH Act regulated that a health care provider is required to honor a patient's request to restrict disclosure of PHI to a health plan for purposes other than carrying out treatment (specifically, payment or health care operations**) if the patient pays the health care provider out of pocket in full**. [Section 13405 of Subtitle D of the HITECH Act (42 USC 17935)].
- This means that if a patient does not wish to use their health insurance or med-pay, they can request that the insurance is not billed.
- A PPO cannot require that you file a claim for the patient, **although if you do not, then you may be required to have a written attestation that the patient requested the restriction.**
- Medicare B is the exception for covered services (ABN APPLIES INSTEAD).

https://www.healthit.gov/sites/default/files/hitech_act_excerpt_from_arra_with_index.pdf

Waiver to File Insurance
(Print On Office Letterhead)
(This form not valid for Medicare patients. Use Medicare Advance Beneficiary Notice- ABN)

[Date]

[Name of Patient]
[Name of Patient's Insurance Company]
[Subscriber ID]

RE: ***Waiver to File Insurance Claims and Election to Self-Pay***

I, _____DOB_____
Understand and agree that *Dr/Name of Clinic*._____ is a participating provider with my Health Plan as shown above. The health plan under which I am covered includes benefits for some, or all of the services provided by my provider.

Despite the above, I do not wish to submit a claim to *Name of Insurance Company*_____ _____ for services provided to me by *Dr/Name of Clinic*._____

Until such time as I may otherwise advise this health care practitioner or clinic in writing, I elect to pay for all services I receive from said practitioner out of my own pocket. By electing to self-pay for services, any payments I make to my provider will not be credited toward satisfying any deductible or coinsurance I may be subject to under my Health Insurance Plan, unless otherwise permitted under the terms of my health plan. I also agree not to retroactively self file or request that my provider file claims, should my deductible be met at a later time during my plan's benefit period. Should I decide at any time to have my provider begin to file for benefits on my behalf, I understand that I must revoke this Waiver to File in writing.

I have read this *Waiver to File Insurance Claims and Election to Self-Pay* form and have had the opportunity to ask any questions I may have had about this form. Any questions about this form have been answered to my satisfaction. I have freely chosen to self pay for services after having asked about payment options and having carefully considered those options.

_____
Signature of Patient or Responsible Party/Parent or Legal Guardian — Date

_____
Witness — Date

SAMPLE WAIVER AND REVOCATION OF WAIVER

REVOCATION of Waiver to File Insurance
(Print On Office Letterhead)
(This form not valid for Medicare patients. Use Medicare Advance Beneficiary Notice- ABN)

[Date]

[Name of Patient]
[Name of Patient's Insurance Company]
[Subscriber ID]

RE: ***REVOCATION of Waiver to File Insurance Claims and Election to Self-Pay***

I, _____DOB_____

Understand and agree that I previously signed a ***Waiver to File Insurance Claims and Election to Self-Pay*** for services provided by *Dr/Name of Clinic*._____ on *DATE* _____ I understand that my doctor/clinic is a participating provider with my Health Plan as shown above. The health plan under which I am covered includes benefits for some, or all of the services provided by *Dr/Name of Clinic* _____.

By my signature below, I revoke my earlier election to self pay for service and direct *Dr/Name of Clinic*._____ to begin billing and filing claims to my health plan for service provided by *Dr/Name of Clinic*._____ , effective *DATE* _____. I understand that the health plan under which I am covered may limit coverage for services provided by my provider, and/or may subject me to a deductible and/or coinsurance that must be satisfied before any benefits are provided under the Health Plan. I understand that I will be responsible for the cost and cost share of any services provided to me by my provider that are not covered by my Health Plan to the extent consistent with the terms of my plan.

As of the effective date indicated above, *Dr/Name of Clinic* _____ will bill claims for services at their contracted rate with said insurance carrier, as a participating provider under this plan.

I have read this ***Revocation of Waiver to File Insurance Claims and Election to Self-Pay*** form and have had the opportunity to ask any questions I may have had about this form. Any questions about this form have been answered to my satisfaction. I have freely chosen to request that my provider bill for services on my behalf, after carefully considering my options.

_____
Signature of Patient or Responsible Party/Parent or Legal Guardian — Date

_____
Witness — Date

COLLECTION RULES AND BOTTLENECKS AT FRONT DESK

- The different collection rules for copay, coinsurance, deductible and self-pay amounts due can cause traffic jams at the front desk.
- Systems need to be in place to streamline patient payments. This might include (when permissible)
  - DMPO's
  - Pre-Payment Plans
  - Auto Pay Systems

OTC COLLECTION LANGUAGE

DON'TS

- Would you like to make a payment today?
- We'll just catch you next time!
- We **Verified** your Insurance benefits. You have a $30 copay, and Your insurance will cover the rest.

DO'S

- Today's visit is $xxx. We take cash, check or credit card
- No worries, we'll just charge your card on file!
- We just **checked on** your insurance benefits. According to XXXX, your chiropractic services may be covered under a $30 copay. But the insurance company would not guarantee benefits, so we can only go by what they said. If it's different than their quote, you may be liable for the difference. *(this should also be written into your financial policy)*

NO STATEMENT POLICY

- Implement a “no statement policy” in your practice
  - Patients must pay at TOS (Co-Pay Before, all others After)
  - **Implement Auto-Debit/E-Pay Options for TOS payments and balance billing**
  - Cash Patients, provide GFE with option to pre-pay, or auto debit a weekly/monthly amount
- Set cash patients up under a DMPO if your cash discounts are more than 15% of billed charges

E-PAY OPTIONS

- Your Practice Management Software (ie: Chiro Touch E-Pay)
- Your Clearinghouse (ie: Trizetto/Gateway)
- Patient E-Pay Companion Apps (ie: InstaMed)

Make sure “No Statement Policy” is included in your Clinic Financial Policy

CLINIC FINANCIAL POLICY, CONT.

_____ **Personal Injury/Workman's Compensation**: Many Personal Injury and Workman's Compensation claims are covered 100%. However the bill is ultimately your responsibility. In order to facilitate a claim, you must provide our office with the documentation necessary to prove a valid claim, as well as the name(s) of any claims adjuster/attorney, etc handling the case, claim numbers and mailing address to send bills. Failure to provide the documentation needed will result in immediate conversion of your case to cash/self pay, and all payment will be due on receipt. If your case is turned over to an Attorney for final settlement, our office will wait up to 12 months for settlement to be completed. Should your settlement case exceed 12 months, you will be required to make monthly payments on your account until such time as the case settles. Should there be an unfavorable settlement on your case, you will be responsible for the balance due, with the exception of any negotiated settlement rates agreed upon by Rise Chiropractic and your Attorney. **Patient Initials _____ Staff Initials _____**

_____ **Patients without Insurance or Limited Benefits**. You will be required to pay for your services at the time they are rendered. You may be entitled to a discount off the billed fees, if you pay in full at the time of service. Your options will be explained to you when the doctor presents your treatment plan.
Patient Initials _____ Staff Initials _____

_____**Payment Plans/Financial Hardship.** If payment at time of service is going to produce a financial hardship, we do offer, with an auto-pay option, a short term payment plan. Please discuss this option with our staff if you feel it is necessary to complete the care you need. We also have available discounts for patients who meet state and/or federal poverty guidelines or other special circumstances. Verification will be required to qualify for a financial hardship discount. **Patient Initials _____ Staff Initials _____**

_____**No STATEMENT POLICY**. Our office has a No Statement Policy. This means we do not send out balance due statements by mail. If you have a balance on your account that needs to be paid, you will.....(state process for receiving notification of bill). Upon notification, you will have the option to pay your bill online. Failure to pay bill in a timely manner (within 10 business days of notification) will result in your authorized credit card being debited automatically for the amount due.

____ I have read and understand the financial policy of _____. I also understand that if I have insurance, or a valid auto or workman's compensation claim, my carrier may pay for some to most of the charges listed above, but no benefits are guaranteed. I understand that I am ultimately financially responsible for all services not paid by insurance or other third party. Should there be a balance due at the end of my treatment plan, I will receive an invoice for the amount and pay it promptly, or contact the office to make payment arrangements.

Printed Name of Patient/Responsible Party _____

Signature of Patient/Responsible Party _____

Date Signed _____ Witness Signature _____

New Patient Payment Policy – Effective 4/1/24

Dear Valued Patient:

In order to streamline your experience at _____Chiropractic, we will be implementing a new patient payment program called E-Pay. This will allow you to conveniently pay your bill electronically/online instead of having to pay at the front desk at each visit. E-Pay will work in the following way:

1. You will need to provide us with a current email address and mobile number.
2. We will provide you with an EPay authorization form, which we will keep on file. You will be asked to update this form annually or any time you have a change to your method of payment.
3. The first time you make a payment with a credit or debit card, your information will be securely stored in our PHI/DSS Compliant E-Pay vault.
4. If you are a CASH/Self Pay patient, payment for all subsequent visits will be automatically processed through E-Pay. You don't have to do anything else, unless you wish to defer payment that day. In that case, you will need to notify our friendly front desk staff, and we will defer your payment to a more convenient date.
5. If you are an insurance patient and are required to pay a CO-PAY for each visit, your CO-PAY will be automatically processed through E-Pay.
6. If you are an insurance patient and have a coinsurance and/or deductible to meet, once your insurance claim has processed, you will receive an email with a link to pay any remaining balance on your claim. Payment must be made within 10 business days of receipt. If you do not pay your bill through E-Pay within 10 business days, or notify us that you need to defer your payment, we will automatically process your balance due.
7. If you wish to change your credit/debit card on file, or your card expires, please let the front desk staff know, and we will update your record
8. If you do not wish to participate in E-Pay and prefer to pay your bill each time you come in, you are still welcome to do so.
9. If you do not wish to participate in E-Pay and have a remaining balance due, a paper statement will be sent to you for the balance of your bill. Paper statements and payments by mail will incur a 5% service fee, which will be added to your balance due.

If you have any questions about this policy, please do not hesitate to reach out to our friendly front desk staff for further assistance.

TO IMPLEMENT AN E-PAY POLICY IN YOUR OFFICE:

1. Set "Launch Date" – 30-60 days. Post notice similar to this one at FD and in treatment rooms
2. Use time before launch to gather cc data and auth forms
3. Set up E-pay platform (based on software)
4. E-Pay is Voluntary, however balance billing by patient statement should incur a service fee to encourage patients toward the e-pay option.

___Chiropractic
AUTHORIZATION FOR AUTOMATIC PAYMENT

I AUTHORIZE ___Chiropractic TO AUTOMATICALLY PROCESS PAYMENTS FOR SERVICES RENDERED THROUGH E-PAY SERVICES, PER THE TERMS OUTLINED IN THE ACCOMPANYING PAYMENT POLICY NOTICE AND AS SET FORTH BELOW.

PATIENTS WITH INSURANCE: If my insurance plan requires me to pay a CO-PAY, it will automatically be processed to my credit/debit card on file upon check in for my visit. If I am required to pay a cost share in the form of a deductible amount or coinsurance, I agree to the following provisions: After my insurance claim has been processed, I understand that I will receive an E-Statement via email for any remaining balance due and will have 10 business days to pay my bill automatically through E-Pay. If I do not pay within the 10 business days from date of receipt, I agree to have any remaining insurance balance attributable to patient responsibility automatically deducted from my credit/debit card on file through E-Pay. This may include, but not be limited to, unpaid co-pays, coinsurance and deductible amounts, services that are billed to my insurance company and deemed to be not covered under my insurance plan; as well as any non-assigned insurance payments that are sent to me directly and not reimbursed to ___Chiropractic.

SELF PAY PATIENTS/NON-COVERED SERVICES: I agree to have any NON-COVERED OR CASH/SELF PAY SERVICES automatically deducted from my credit/debit card on file through E-Pay.

PATIENTS WHO CURRENTLY HAVE A PAST DUE BALANCE AT ___CHIROPRACTIC:

_____ I agree to a one-time payment of $_____ to clear up my balance due.

_____ I agree to be billed monthly/weekly (circle one), until my account is paid in full. Amount $_____ I understand that weekly payments will be processed each Friday. Monthly payment will be processed on or around the 5th of each month. I understand that during this repayment period, I will also be required to maintain a "zero" balance on any future services rendered.

I have provided ___CHIROPRACTIC a valid credit or debit card and email address in which to process my E-Pay payments. I authorize Jeffries Chiropractic to email me a link that I can use to pay my bill online.

I agree to the above terms and authorize you to process the automatic payment(s) as set forth above. I understand that should my payment be declined, I will be charged the entire amount outstanding on my account, and payment of full invoice will be due immediately. If my card expires or is no longer valid, I will give ___CHIROPRACTIC a new method for automatic payment. I understand that this authorization is valid for up to 12 months from date of signature. I understand that I may decline participation in this program at any time and pay my bill in person or by mail by notifying ___Chiropractic in writing. I further understand that in-person or by mail payments will incur a 5% service charge of the balance due on my account.

Signature _____ Date _____

PRINT NAME _____

ADDRESS_____ City_____ Zip_____

DAYTIME PHONE_____ E-MAIL _____

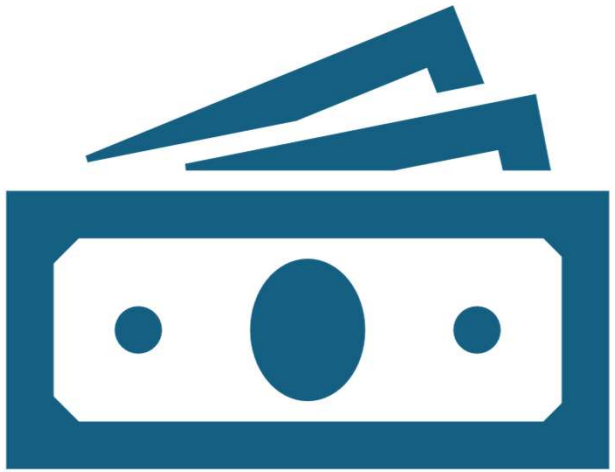
Witness _____ Date _____

PRINT NAME _____

Credit Guarantee for Personal Balances

SAMPLE AUTHORIZATION FORM FOR E-PAY AND AUTO DEBIT

- ✓ Inform patient of "No-Statement" policy in Written Financial Policy
- ✓ Introduce E-Pay Option
- ✓ Capture CC info the first time they pay, place in payment vault
- ✓ Future services are automatically processed, no need to stop at Front Desk
- ✓ Can be used for past due bills
- ✓ Renew form Annually or if CCOF Changes



OTHER PAYMENT OPTIONS

MEDICAL CREDIT CARDS

- H.S.A./M.S.A. DEBIT CARDS THROUGH PATIENT'S INSURANCE PLAN (Usually Compatible with E-Pay Systems)
- CARE CREDIT https://www.carecredit.com/
- ACCESS ONE https://accessonepay.com/

Thank you!

CONTACT US FOR A FREE 30 MINUTE CONSULTATION TO DISCUSS YOUR NEEDS!

Lisa Maciejewski-West CMC CMOM CMIS CPCO-I

info@goldstarmedical.net

www.goldstarmedical.net

866-942-5655 Office

Self Serve Scheduling Tool:

https://calendly.com/lmaciejewski/