Dr. James B. Gerni, D.C.
216 West 19th Street
Connersville, IN 47331
Phone (765) 827-0393

OFFICE AND PAYMENT POLICY FOR MEDICARE

This office will accept payments from Medicare according to the specific benefits of your policy. Your coverage will be discussed. All policies will be subject to the following requirements of this office:

1. Medicare **only** pays for chiropractic **manipulations** of the spine for treatment of symptoms caused by a spinal subluxation. This is the approved service. Medicare pays 80% of the $33.51 which is $26.81, of the spinal manipulation.

2. Medicare does **not** pay for any other services. These are called unapproved services, which include nutritional supplements, exam fees, treatments, orthopedic aids, pillows, nutritional counseling or allergy testing. You will be responsible for these fees if you choose to have these services/products.

3. Medicare no longer requires yearly x-rays. If the physician feels x-rays are necessary in your case, you will be responsible for those charges. Medicare will not pay for x-rays at this office.
4. You are to pay the 20 % of the $33.51 which is $6.70, at the time of service listed above in #1.

5. You are to pay 100% at the time of service for the unapproved services listed above in #2.

6. Your yearly deductible is payable in full at the time of service. Only the approved service – spinal manipulation – is applied towards your deductible.

7. It is your responsibility to keep record of your dealings with Medicare. When we receive a payment or a denial, you receive the same documentation from Medicare. If you do not receive this from Medicare then you will need to contact them. This document is necessary for you to file to your secondary insurance, if you have it.

8. We will file your covered services to Medicare. You are responsible to file your supplementary/secondary insurance.

9. You send your Medicare Summary Notice that you will receive from Medicare along with your paid receipt and supplemental/secondary insurance form to your company.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. Furthermore, I understand that I may be assisted with and may be charged for completion of reports required by the insurance carrier, in order to pay benefits. I clearly understand that I may be charged 1.5% per month, 18% annually, for any account balance due over 30 days.

If you discontinue care and your balance is not paid within 30 days, you may be turned over to our collection department. You would then become responsible for any and all collection costs, attorney fees as well as any and all court costs accrued while attempting to collect money owed to this office.

I acknowledge being given notice of Medicare coverage and possible denials

I understand that my visit may be determined not medically necessary due to:

Your condition is not caused by a spinal subluxation. _____

In my judgement, your care requires more visits than the number allowed by Medicare. _____

Treatment that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition is not a Medicare benefit.
Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically necessary under the Medicare program. _____

Carrier local review policy may determine this level of service as not medically necessary. _____

Under these circumstances you will be responsible for payment of the denied charges.

Signature _____

Date of Service _____

Witness _____

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OFFICE AND PAYMENT POLICY

Our office will be pleased to verify your insurance coverage.

Our office does not guarantee that your insurance company will pay. We will make every effort, at the beginning of your health care, to confirm verification of your policy and coverage. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill, at that time.

With changes in the Nation's health care systems, which you are already aware of, you are responsible for your deductible, all co-payment, and any non-covered or denied services or items.

Your insurance contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance company.

In submitting your insurance claims for you, we wait for payment. This courtesy may be withdrawn if circumstances warrant.
We will bill your insurance company regularly. When payment is received, we will bill you for any balance due. Your insurance should pay within 30-60 days from filing. If your insurance has not paid within that time, you must pay the balance due. If the insurance then pays later, a refund will be paid to you or a credit applied to your account, whichever you request at that time.

We will resubmit any unpaid/missing claims one time, in an effort to get a response from your insurance company when none has been received with the first submission.

It is your responsibility to keep record of your dealings with your insurance. Any time we receive a payment or denial, you should receive the same documentation. We will, upon request, help you itemize your account if you have lost or not kept your records. This will be done as a separate and chargeable service.
If you do not receive this important documentation from your insurance carrier, you need to call them.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. Furthermore, I understand that I may be assisted with and may be charged for completion of reports required by the insurance carrier, in order to pay benefits. I clearly understand that I may be charged 1.5% per month, 18% annually, for any account balance due over 30 days.

If you discontinue care and your balance is not paid with 30 days, you may be turned over to our collection department. You would then become responsible for any and all **collection costs**, attorney fees as well as any and all court costs accrued while attempting to collect money owed to this office. In this office we use Connersville Credit Bureau for any unpaid balances over 30 days.

Absenteeism slips will be given at the discretion of this office. If for any reason you fail to follow this office's recommendations or miss an appointment after the slip has been given, we will be unable to substantiate your condition to warrant the necessity of absence.

Patient's signature _____

Date _____

Witness _____