



**Your Wellness Connection, P.A.**

7410 Switzer / Shawnee Mission, KS 66203  
Phone (913) 962-7408 Fax (913) 962-7416  
www.yourwellnessconnection.com

## Financial Relationship

Client's Name: \_\_\_\_\_ Client's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Most of our clients who have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.**

### HEALTH INSURANCE

- As a courtesy to you, when given a copy of your insurance card, we will call and find out your benefits for Chiropractic and/or Counseling care in our office.
- We do not file claims for **Acupuncture, Massage, Lab Work, Orthotics, Supplements or Merchandise** to your insurance.
- If you receive care that we do not file for, you will need to pay for the services when rendered. If you would like to submit the charges yourself for reimbursement, we will be happy to make a copy of your fee slip.
- Please remember – the benefits information your insurance company quotes us is **not a guarantee of payment from them.**

Insured's Name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

### MEDICARE

- Medicare covers for **spinal adjustments** only. After your yearly deductible has been met, Medicare should cover 80% of the allowed cost for adjustments. You will be responsible for the remaining 20%, as well as the cost for any non-covered services you receive.
- You will be asked to fill out an *Advanced Beneficiary Notice* for non covered services.

### SECONDARY INSURANCE

- Please inform us of any secondary insurance you may have. We will be glad to file chiropractic and counseling claims to your secondary insurance after your primary insurance has processed the claim(s).

### PERSONAL INJURIES OR AUTO ACCIDENTS

- If you have not already done so, please notify your auto or personal injury insurance carrier of your accident immediately. We will have you fill out the proper documents so we can file claims to the responsible party. It will be helpful if you know your insurance company's *phone number, policy number, and accident claim number* when you fill out the paperwork. We will call your Adjuster to gather the information we need in order to file.
- If you reach the maximum amount payable under your auto insurance, we will file the claims to your Health Insurance.
- Although you are ultimately responsible for your bill, we will do whatever we can to secure reimbursement from your insurance carrier. Once the claim is settled or if you suspend/terminate care against physicians recommendations, any remaining fees are due immediately from you.
- If there is a 3<sup>rd</sup> party involved (such as an attorney), you will be asked to make partial payments as care is received.

### ON THE JOB INJURY(Worker's Compensation)

- If you are injured on the job, care should be paid for under your employer's Workers Compensation insurance. You will need to inform your employer of the accident immediately and obtain the name & address of their insurance carrier. If you or your employer do not provide us with this information, or if you terminate/suspend care, any fees for services rendered are due immediately from you.

### CLIENTS WITHOUT INSURANCE

- We request that 100% of the first visit be paid at the time of service.
- On other visits, payments may be made at the beginning or at the end of the week.
- We gladly accept cash, checks, credit cards, or Care Credit (ask the front desk about the great Care Credit plans that we have available).

I have read and understand the financial policy of Your Wellness Connection. I understand that my insurance is an arrangement between myself and my insurance company, *not* between Your Wellness Connection and my insurance company. I also understand that a final determination of my benefits cannot be made until my claims are processed by my insurance company. I request that Your Wellness Connection prepare the customary forms at no charge so that I may obtain insurance benefits.

Is today's visit due to an accident?  Yes  No

I have read the above payment terms and understand my payment responsibilities. \_\_\_\_\_ Initial here

# YWC Insurance Verification

Date	Contact Name
Eff. date of coverage	
Deductible In Net How much met?	Out Net
Co-Pay(s)	
Chiro Mass Acup	Exam Therapies
Co-Insurance	
% After ded? Max OOP?	
Max Benefits/Yr	
Chiro Mass	Acup
Auth / Referral?	
Auth #	
Claims address checked?	
Yes                      No	
X-rays covered in our office?    Yes    No	
If yes, how?	
Acupuncture covered by OON Acup?	
Yes                      No	
If yes, how?	
Caller _____ Entered in Client Profile by _____ on _____ Client informed of benefits on _____ by _____	Massage covered by OON MT? Yes                      No If yes, how?

<b>SPECIAL PAYMENT INSTRUCTIONS</b>	
Client's Name: _____	Client's Date of Birth: ___/___/___
Insurance Deductible: _____ Met: _____ % _____ Copay: _____ OOP Max: _____	
Notes: _____ _____	
Clients Signature: _____	Date: ___ / ___ / ___      Witness: _____
<b>This is Not a Guarantee of Payment from Your Insurance</b>	