

DrTri Whole Health & Fitness

4828 California Ave SW Seattle, WA 98116 Ph: 206.932.7943 Fax: 206.932.8686

Account Policy:

1. Payment is expected at the time of service.
2. As a service to you, your insurance company will be billed. If DrTri/Seattle Whole Health & Fitness can document your coverage, they will ask you to pay at the time of each office visit, the amount your insurance company will not pay. This may be a deductible, percentage fee or co-pay.
3. You will be expected to pay for all non-covered services, supplements or supplies at the time they are presented to you.
4. If for some reason, the information obtained from the insurance company is inaccurate, or services that were thought to be covered are not paid for, you may be informed of a balance due. **Information from insurance companies is not a guarantee of benefits.** You are responsible for all charges incurred while under care in this office.
5. If you have a personal injury (motor vehicle accident) claim, we will bill your insurance company. If the insurance company does not cover 100% of your bill, you will be responsible for the difference. It is expected that if an attorney has been assigned to your case, a lien will be signed for assignment of benefits for services.
6. Dr. Ross and DrTri/Seattle Whole Health & Fitness bill parties, including insurance companies, valid and appropriate codes for services that fall under the scope of practice, as defined by WAC 246-808-505 and RCW 18.25.005 (available upon request), for Chiropractic in the State of Washington. In addition, Dr. Ross and DrTri/Seattle Whole Health & Fitness bill the appropriate and reasonable amount for services as defined by WAC 246-808-540 and RCW 18.25 for care.

I authorize payment directly to my provider at DrTri/Seattle Whole Health & Fitness and their affiliates for services rendered to me. I understand and agree that health and accident policies are a contract between my insurance company and myself. I also understand that if my insurance provider refuses payment, my services are not billable to insurance or my deductible has not been met, I am directly and fully responsible to said provider for all bills submitted by them for services rendered to me. I understand that all co-payments (and applicable supply charges) are due at time of service. I also understand that verification of benefits prior to services rendered is my responsibility and some services may not be covered by my individual insurance policy. Payment for these services are my responsibility.

DrTri/Seattle Whole Health & Fitness will only be accepting limited insurance companies for billing and payment for services. It is important that you verify your benefits with your insurance company.

Due to the unfair reimbursement/payment from some insurance companies, DrTri/Seattle Whole Health & Fitness can no longer afford to bill them. The office will provide you with the necessary paperwork to submit to your insurance carrier for reimbursement if needed.

I have read and understood the above.

X _____ Date: _____

Cancellation Policy:

I understand that twenty-four (24) hours notice is not only appreciated, but also required when canceling an appointment. I also understand that I will be directly charged (insurance does not cover missed appointments) for missed appointments that I do not cancel according to the twenty-four hour policy, and I agree to pay for as such. Standard charge is \$50.00.

I have read and understood the above.

X _____ Date: _____

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Please initial each item below:

- _____ I authorize Dr. Ross to provide Chiropractic, Exercise Rehabilitation, and/or Manual Therapy services to me.
- _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by Dr. Ross.
- _____ If my account is assigned to an attorney for collection and/or suit due to delinquency, the prevailing party shall be entitled to Attorney's fees and cost for collection.
- _____ I authorize any insurer to make payment for services rendered by Dr. Ross, directly to Dr. Ross, at DrTri/Seattle Whole Health & Fitness 4828 California Avenue SW, Seattle, WA 98116
- _____ I authorize the release of records to third parties requiring records for determination of financial liability.
- _____ I have directly verified benefits with my insurance company for specific coverage relating to care under Dr. Ross. And I also understand that any remainder amount due, after insurance has paid their allowed amount, is solely my responsibility.
- _____ I understand that information from insurance companies is not a guarantee of benefits. Information gained from insurance companies via telephone and/or the coverage manual may vary from their actual payment and reimbursement amount.

By signing this paper, I affirm under penalty of law that I have given true and complete information.

Patient Name: _____ Patient Signature (minors included): _____

Responsible Party Signature (if patient is a minor): _____

Relationship to minor: _____ Date: _____

Consent to Treat:

Chiropractic examination and therapeutic procedures (including spinal and/or extremity adjustments, heat/cold application, mechanical traction and manual muscle therapy) are considered safe and effective methods of care. However, any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of Dr. Ross to inform their patients about them.

These complications include, but are not limited to: soreness, inflammation, soft tissue injury, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient Name: _____

Patient Signature: _____

Release of Information:

I give permission to my provider and staff to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, case manager, attorney, and related healthcare provider. I understand that all release of information is contingent upon prior approval in writing by myself.

I have read and understood the above release.

X _____

Date: _____

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Date: _____

Name : _____

Birthdate: _____

Gender: Male/Female

Street Address: _____

City/State/Zip: _____

Home Telephone : _____ Cell Phone number: _____

Which number is it best to contact you/leave messages at?: _____

Employer : _____

Work Telephone : _____

Email Address : _____

Emergency Contact : _____ Tel: _____

Present Complaint: _____ Date onset: _____

Previous treatment:

Insurance:

See Card OR

Name of Insurance Company : _____

Insurance Address: _____

Contact Information : _____

Policy #: _____ Group #: _____

L/I or PIP Claim no: _____

All the above information is true and correct to the best of my knowledge. I have also read and signed the additional waiver and release of information and privacy statement.

SIGNATURE: _____