



209 Main st, Unit E
Mead, CO 80542

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E-Mail: info@alcmc.com Web: www.alcmc.com

Financial Policies

Health Insurance:

Assignment of Benefits:

I hereby assign payment directly to Active Life CMC, who represents this clinic to payor groups for medical benefits payable to Active Life CMC. I will update billing information as soon as any changes occur in my insurance coverage including my address and personal contact information.

The insurance (managed care) industry manages your care and dictates what they will pay for based on what they feel is medically necessary. I understand my health insurance is a contract between myself and insurance carrier. As a service to our patients, we will bill insurance companies for services rendered, will resubmit a denial only one time and allow a total of 60 days for complete payment. No guarantees of coverage are implied by Active Life CMC. Unique plan requirements like pre-authorization, whereby such requirement is not clear in the initial verification of benefits process, are the responsibility of the patient to be compliant with as those requirements are not always clearly apparent at verification of benefits. Any denials over pre-authorization requirements default to our policy of billing patient's insurance one time correctly based upon our review of your benefits portal.

I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment; including any denials for any reason. Any unpaid balances after 60 days will become patient responsibility and I understand these charges will be charged to my credit card on file 10 business days after notification via phone and/or email. I understand that I will be held responsible for any costs incurred regarding collection of payment for services rendered, including 40% charge if we must send to our collection company, as well as any statement fees, late charges and 18% annual interest.

Initial _____

Auto Cases:

We do require a credit card on file. If there is no med-pay, we will keep the credit card on file until the account has been settled. We do reserve the right to charge the credit card if the case has been settled and we have not received payment or correspondence within 60 days. We do offer a 20% discount for payment in full within 60 days of the date of dismissal from active care. Without Med-Pay benefits or after Med-Pay benefits are exhausted we will charge a \$125/month charge to apply towards the balance. **We DO NOT bill health insurance** for auto cases due to the higher documentation standards necessary to document impairment, causation, etc. and expanded treatment times due to the widespread injuries related to an auto accident.

Initial _____

Missed Appointment:

Active Life Requests that appointment cancellations be made AT LEAST by the day before a scheduled appointment. We have voicemail available 24 hours a day, 7 days a week and email should you need to cancel during non-office hours. We are aware that unforeseen events result in a missed appointment and understand if appointment cancellations be made same day. However, Habitual no-shows or late cancellations will result in a \$30 CANCELLATION FEE and potential dismissal from clinic. It is to the discretion of the doctors to dismiss the patient from the clinic.

Initial _____

Release of Records:

I do ___/ do not _____ authorize other healthcare providers to **release or obtain any medical records**, images, or reports to/from Active Life CMC for the purpose of providing or obtaining medical information pertaining to my treatment. I will specify any restrictions to any party I authorize to receive said information from Active Life CMC. Note any limitations to that information ie) time period, type of records, etc.

Minors:

Minors are welcome to come without their parents for their visits. However, if a parent is not going to accompany the child we do require a credit card on file that will be charged after each visit for any applicable co-pays, co-insurance, or deductibles.

Initial _____

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and have, therefore, been advised of how health information about me may be used and disclosed by Active Life CMC and how I may obtain access to and control of this information.

Initial _____

Name (print): _____

Signature: _____ **Date:** _____