

# MONTEREY BAY WELLNESS CENTER

MONTELLESE FAMILY CHIROPRACTIC, INC.

Dr. Christopher Montellese, DC

Dr. Kristina Montellese, DC

## FINANCIAL POLICY INSURANCE, CASH, AND MEDICARE

### INSURANCE

It is the policy of this office that you pay for your visit in full at the time of each visit. We will verify your health insurance coverage for chiropractic care, for you. Once your eligibility and coverage is determined we will file all insurance claims for you to the extent that your policy permits.

You are responsible for paying your deductible, co-payment and non-covered supplements, supplies, and services at the time they are rendered.

### NON-INSURED

We request that you pay for all services in full at the time of each visit.

If your financial situation requires special arrangements, please speak with our Front Desk Staff.

### MEDICARE

Dr. Kristina E. Montellese and Dr. Christopher G. Montellese are Participating Providers with Medicare therefore; we are required to bill Medicare for services. **Medicare does require that you pay for X-rays, examinations, supplements, supplies, physical therapy and any other non-covered services, and therefore you will be asked to pay for these services at the time you receive them.** You will also be required to pay all visits in full. Medicare will send payment directly to YOU.

### **IT MUST BE UNDERSTOOD:**

1. This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged.
2. The clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. **This is the patient's obligation.**
3. We do not file secondary insurance, other than Medicare. If you have more than one insurance and would like to bill it, we will supply you with a copy of our insurance billing to use in submitting bills to your second insurance, upon your request.

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Patient's Signature \_\_\_\_\_ DATE \_\_\_\_\_