# Performance Chiropractic

## Medical Insurance Information

Patient: _____ Primary Insured: _____

Patient SS#/ID#: _____ Primary Insured SS#/ID#: _____

Employer: _____

Claim Group: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: Performance Chiropractic, 5480 Reno Corporate Dr., Suite 200 Reno NV 89511

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: Performance Chiropractic, 5480 Reno Corporate Dr., Suite 200 Reno, NV 89511

### Clinic Financial Policy

1. Insurance
    a. All patient responsibility amounts will be due at the time of service, once your insurance coverage has been verified and your insurance company has informed us what portion of the payment is your responsibility.
    b. All procedures performed by the physician will be billed to insurance. Performance Chiropractic will bill for the patients and will abide by the contract for that particular insurance. All charges not covered by insurance will be due immediately from the patient, i.e.: co-pays, deductibles and percentages that are due per the insurance. *When we are contracted with an insurance panel, we are required to collect based on what is contracted by insurance.*
    c. Insurance is billed as a courtesy and any discrepancies will be between your insurance company and yourself. We are happy to help in what way that we can, however, you are legally responsible for any balance.
2. Payment Options
    a. The "Time of Service" price is the price that is paid when a visit is not billed to insurance and is $40.
    b. If there are extra services during a "Time of Service" visit such as heat, ice, physical therapy/rehab services, etc., those will be billed in addition to the adjustment, but will be approved in advance by the patient.
    c. If payment for a non-insurance visit is not made at the time of service, we will bill out at the same rate that we bill for insurances, for all procedures done. There will be an automatic 30% discount for non-insurance, and the patient will be responsible for those costs.
    **d. A punch card of 10 visits can be purchased for a price of $300 and can be used by any member of your household.**
    e. Hardships, by law, are a reduced payment for services for a fixed amount of time. Any hardship cases must be approved by Dr. Gomez in advance, and will last a pre-determined amount of time based on need, but no more than 6 months.
3. If you have a credit balance, we will reimburse you after payment has been received or credit your account.
4. All accounts with balances will be sent via email or by mail every month. All balances over 45 days old will accrue a 2% charge on the account per month.
5. Personal injury and auto accident cases will be billed to your auto insurance company, providing that a claim has been filed and the appropriate paperwork has been completed. If you chose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service. By signing this agreement, you agree to forward the charges in full if you are paid directly, unless otherwise agreed upon by your MVA insurance and this office.
6. Generally, supplements/vitamins, lab tests, supports and other supplies may not be covered by insurance companies and **must be paid for at the time they are received**. Should your insurance company pay, we will reimburse you for the amount paid.
7. By signing this document, you are authorizing Performance Chiropractic or Dr. Aric Gomez to bill your insurance and your signature is considered "on file" for this purpose. You are also agreeing to terms within this contract.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____ _____

Signature of Policyholder Date Witness

Signature of Claimant, if other than Policyholder