

FULLER HEALTH WELLNESS CONTRACT

*The goal of the Fuller Health Group is to promote total wellness: of the mind, body, and spirit.
By consenting to treatment, we are asking you to make a commitment to yourself.*

*Treatment is not about a simple adjustment,
rather a promise to understand the cause of your condition.*

Please indicate that you are on board by signing below.

SIGNATURE _____ **DATE** _____

FULLER HEALTH GROUP PC FINANCIAL POLICY

Patient Last Name _____ First Name _____

Street Address _____

City _____ State _____ Zip _____

Cell (or preferred) Phone _____ Other Phone _____

Email (REQUIRED) _____

Birth date _____ Age _____ Sex M F

Single Married Domestic Partnered Widowed Separated Divorced

Social Security # (required for insurance processing) _____

**It is the policy of the Fuller Health Group, PC to keep a credit card on file for all patients.
Without a card on file, appointments cannot be held.**

CREDIT CARD # _____ EXPIRATION DATE _____

3 or 4-Digit Security Code _____ Billing Zip Code _____

CARDHOLDER'S SIGNATURE _____ **DATE** _____

SELF-PAY PATIENTS

If you will not be going through insurance your balance is due at the time of your visit.

\$175 Initial visit, or visits treating new acute pain

\$65 Follow-up visits

_____ **Please initial here if you do not have insurance.**

INSURANCE PATIENTS

Please provide your insurance card for photo copy, along with a valid driver's license and credit card.

Primary Insurance Provider _____

ID# _____ Group # _____

Fuller Health Group, PC can bill for both IN and OUT of network plans. Fuller Health is currently In Network with **Blue Cross/Blue Shield, Aetna, and Cigna.**

Insurance cards are required at every visit. We will verify your insurance coverage at the time of your first visit. Depending on your insurance, Fuller Health Group, PC will be reimbursed based on a percentage of the amount billed. We do not know the exact amount **until we receive payment.** All co-payments, deductibles, and payments for non-covered services (nutrition, homeopathy, herbs) **are due at the time of service.** We will submit a claim one (1) time on the patient's behalf.

As the recipient of services from Fuller Health Group, PC, you are ultimately responsible for all services provided. Our office will submit a claim one (1) to your Health Insurance Provider. Fuller Health Group, PC is under no obligation to pursue reimbursement on the patient's behalf other than the one-time submission of the claim. If payment from your Insurance Provider is not received in full within thirty (30) days after submission of the request for payment, a courtesy letter will be written to your attention notifying you that your bill has not been paid. It is thereafter your responsibility to ensure that your health insurance pays your bill for services. If payment is not received in full within sixty (60) days, by providing your card and receiving provided services, you are authorizing Fuller Health Group, PC to charge your provided credit card for any unpaid bills or claims.

Without a card on file, payment is due in full at the time services are rendered. Any claims paid after your credit card has been billed will be refunded to the patient.

It is not the responsibility of Fuller Health Group, PC to continually track your coverage. If there is a lapse in your coverage or you have maxed out your coverage you are responsible for payment in full of the billed amount. (Please see the last page for our menu of services.)

If there are any changes to your insurance including, but not limited to, new insurance member identification number and/or group number, please inform the office. Not updating your personal information can delay and/or deny your insurance claims. If you have not provided our office with the correct insurance information, you will be responsible for any balance due. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

_____ **Please initial here stating that you understand your responsibility to pay your bill in full. Your initial also indicates an understanding that you are not guaranteed coverage by insurance for all bills and expenses.**

MASSAGE POLICY

Because not all insurance companies handle massage in the same way, we collect a reduced massage fee at time of service for all patients without exception:

\$40 for 30 min & \$80 for 60 min

As a courtesy, we will submit this to your insurance company and, if covered, you WILL get your money reimbursed in accordance with the offerings of your health care provider. This will happen in one of the following ways: a check from Fuller Health Group, a credit for service, a payment towards any current balance you hold with Fuller Health Group

This policy protects both you and Fuller Health Group and ensures that we are able to continue offering this crucial practice as a part of your treatment plan.

 Please initial here indicating you understand and will comply with this policy. You will be notified by the front desk whenever payment is needed.

ASSIGNMENT OF BENEFITS TO DOCTOR

(For insurance patients only)

In considering the amount of medical expenses to be incurred I, the undersigned, have insurance and/or employee health care benefits coverage with the above mentioned Health Insurance Provider, and hereby assign and convey directly to Fuller Health Group, PC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

SIGNATURE OF PATIENT _____ **DATE** _____

SIGNATURE OF INSURED/GUARDIAN _____ **DATE** _____
(if different than PATIENT)

WORKMAN’S COMPENSATION

We are happy to accept your workman’s compensation claim. You will need to provide us with the appropriate documentation, including your claim number and claim representative’s contact information at the time of your visit. All services not covered by the claim will be your responsibility.

CLAIM # _____ **DATE OF INCIDENT** _____

MONTHLY BILLING STATEMENTS

Every month our office sends out a monthly billing statement to every patient with a balance due. The balance due is the remainder owed after your insurance has paid. It is your responsibility to pay your monthly statement each month even if you and your insurance company are disputing coverage. After 60 days, all appointments will be suspended until payment is received.

COLLECTIONS

If your account balance is unpaid and overdue after 60 days, and you have not responded to any of our attempts to contact you, your account will be debited via your credit card on file. Our collection agency, First Federal Credit Union, will handle outstanding balances if we cannot collect payment after 60 days. They can be reached at 800-559-9277.

PAYMENT PLANS

If you have negotiated a payment plan with us, we will debit the card we have on file for the agreed upon amount until the bill is paid in full. These payment plans are offered as a courtesy to our patients in a time of need.

_____ **Please initial here stating your understanding of this policy.**

EXCHANGE OF MEDICAL INFORMATION

All requests by patients for medical information must be signed in writing by letter, fax, or a medical release of information form.

DIAGNOSES CODES

Fuller Health Group cannot recode an office visit because your insurance plan does not cover certain visits; this is illegal and considered fraud. It is your responsibility to know what your insurance plan covers. Always call your insurance company to verify coverage. It will be your responsibility to pay any unpaid balance that your insurance company does not cover within 30 days.

PRESCRIPTIONS

The scope of Dr. Fuller’s practice prohibits him from prescribing, recommending, or prohibiting medications. Patients are instructed to always consult a medical physician before changing prescriptions.

CANCELLATION POLICY

We ask that you provide Fuller Health Group at least 24 hours advance notice if you need to cancel or change your appointment time. If you do need to cancel after the 24 hour period, please note that your credit card on file will be charged \$60.00.

I UNDERSTAND AND AGREE TO THE POLICIES OF THE FULLER HEALTH GROUP, PC.

SIGNATURE OF PATIENT _____ **DATE** _____

SIGNATURE OF INSURED/GUARDIAN _____ **DATE** _____
(if different from PATIENT)

REFERRAL PROGRAM

If you know of a friend or relative who would enjoy our services, we offer a complimentary visit to you for each referral that comes in for an appointment. If you wish, we can contact the provided name and number below.

RERERRED _____ **RELATION** _____

PHONE NUMBER _____