Financial Policy

Thank you for choosing Sycamore Chiropractic and Nutrition, LLC. We are committed to providing the best care possible. This goal is best achieved by letting you know in advance of our financial policy, which is an agreement between the doctors of the practice and the patient. Please read this carefully and if you have questions please do not hesitate to ask a member of our team. We require a signature to document that you have read and understand these policies.

INSURANCE

- We must emphasize that as providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know the benefits your insurance plan provides for you.
- A current insurance card must be presented at check in for every visit. If the insurance company that you designate is incorrect, you will be responsible for payment.
- We will not bill another insurance carrier supplied later if it is past the timely filing period for that insurance company. If you are insured by more than one insurance company, our office needs to have all insurance policies on file.
- According to your insurance plan, you are responsible for all co-payments, deductibles, and coinsurances. When we verify that your deductible has not been met, we will collect up to our contracted rate with your insurance company at the time of service. Any amount due after your insurance company processes the claim and notifies Sycamore Chiropractic and Nutrition, LLC will be billed directly to you.
- Co-Payments are due at time of service. Co-payments are a contractual obligation between you and your insurance company. If multiple family members are being seen, they will have a separate charge and co-payment collected as required by insurance.
- If your insurance company does not cover a service, the amount must be paid in full within 30 days of denial from the insurance company. If not insured, Sycamore Chiropractic and Nutrition will allow you to pay out of pocket at a discounted rate. That amount is due at the time of service.
- Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is your responsibility to understand your benefit plan, including needs for referrals or authorization for specialty care, lab tests and other services that may be required. Please note physicians follow accepted national guidelines when determining your charges. They must code based upon what services were provided and cannot consider health plan benefits.

BILLING

- We will provide you with an itemized statement each month when there is a balance due. We accept cash, checks, MasterCard, Visa, Discover, American Express and Apple Pay.
- We will charge your account a $35 non-sufficient funds charge if your check is returned to us.
- We appreciate the difficulties involved in divorce and court orders. Sycamore Chiropractic and Nutrition will not participate in disputes between custodial and noncustodial parents regarding our patients who are minors. We will refer to the responsible party as the person who signs the financial policy, for reimbursement of any amounts due.
- Balances are due within 30 days of the first statement unless prior arrangements have been made with the billing department. Please call if you have questions about your bill.
- Staff will be collecting payments at check in on all accounts with balances that are more than 30 days past due. If you are having difficulty paying your bill, please contact the billing department.
- Should your account remain outstanding more than 90 days, a final letter will be issued. Balances not paid in full within the 10 days of the date on the final request letter may be forwarded to an outside collection agency.

- **Past Due Accounts:** If your account becomes past due, we will take the necessary steps to collect that debt. We will make every attempt to set up payment arrangements with families that are going through a financial hardship. If we must refer your account to a collection agency, you may be charged additionally for any collection agency costs incurred. If we must refer collection of the account to an attorney, you may be charged additionally for any attorney fees we incur, including court costs. Please note that if your account is referred to a collection agency or an attorney for collection, the physicians of Sycamore Chiropractic and Nutrition may no longer be able to provide care for you and/or your family. In this case the guarantor of the account will be notified by certified mail and will be given adequate time (30 days) to find a new provider.

MISSED APPOINTMENTS

- Please notify us as soon as possible if you need to cancel an appointment as someone else may want the time slot reserved for you. **A charge will be billed to your account for all appointments not cancelled within 24 hours of appointment.** The charge will be based on the type of appointment and the amount of time allotted for the appointment, **and could be as much as $75,** and will be charged per patient scheduled. We will attempt to notify you of an appointment within 24 hours of your scheduled visit, but ultimately, it is your responsibility to call us to cancel if you cannot keep your scheduled time. Should missed appointments become habitual, the physicians at Sycamore Chiropractic and Nutrition may choose to no longer care for you and/or your family. In that case, the guarantor of the account will be notified by certified mail and will be given adequate time (30 days) to find a new provider.

OTHER

- **Forms and letters:** We are happy to fill out any necessary forms required by outside entities. Please contact the office for instructions or feel free to drop the form(s) off to one of our team members at the office. There will be a $30.00 charge for forms filled out, payable at the time the form is picked up. We ask that you allow 48 hours for the completion of all forms that are presented to Sycamore Chiropractic and Nutrition, LLC.
- **Records:** The charge for record transfer will be made per child in accordance will State of Ohio Records. Please ask at the time you request your records. There is no charge for records faxed to specialists.
- **Functional Medicine Patients:** The fee for a one-hour new-patient appointment is $350.00, to be paid at the time of scheduling the appointment. The new patient appointment may be rescheduled one time at no cost. If you choose to cancel your appointment and not seek services, $100.00 is non-refundable.

FINANCIAL AGREEMENT

We appreciate your compliance with these policies. We strive to provide excellent, cost effective care in an ever-changing health care environment. We are happy to discuss any questions you have about these policies.
The undersigned agrees with the terms and conditions listed in the financial policy. By refusing to sign this financial policy, I agree to pay in full at the time of service. I certify that the information I have given to Sycamore Chiropractic and Nutrition, LLC is accurate. I hereby authorize Sycamore Chiropractic and Nutrition to furnish my insurance company all they may request concerning the patient's present illness or injury. I hereby assign to Sycamore Chiropractic and Nutrition all benefits for service rendered.

I have read and understand the Financial Policy from Sycamore Chiropractic and Nutrition. I agree to adhere to the above written policies, and all questions have been answered.

Patient Name (Please Print)

Patient Signature

Date

Sycamore Chiropractic and Nutrition Designated Privacy Official: 513-773-1214

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Sycamore Chiropractic and Nutrition's Notice of Privacy Practices effective September 21, 2020.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restriction.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, and send a text to you to confirm appointments?	☐ YES	☐ NO
May we leave a message on your phone?	☐ YES	☐ NO
May we discuss your medical condition with any other family member?	☐ YES	☐ NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Informed Consent to Treat

Thank you for trusting Sycamore Chiropractic and Nutrition with your health! We provide functional medicine counseling, nutritional counseling, chiropractic care, and massage therapy. Because you have chosen to engage one or more of these modalities, we ask you to sign this consent form:

I hereby request and consent to the performance of nutritional therapy and counseling, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy (including but not limited to massage therapy, muscle stimulation, ultrasound, and stretching), and diagnostic X-rays on me and my family members (or on the patient named below for whom I am legally responsible) by Dr. David Boynton, DC, CCEP, or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss my health care needs and the nature and purpose of chiropractic adjustments and other procedures and counseling with Dr. Boynton, DC, CCEP and/or with other office or clinic personnel. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely upon the doctor to exercise judgment, based upon the facts then known to him or her, in providing treatment which the doctor feels is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I agree if I am pregnant or trying to get pregnant that I will inform the doctor immediately.

_____ _____

Patient Signature Date

_____

Patient Name

Consent to treat a Minor

I _____(☐ Mother, ☐ Father, ☐ Guardian) give

permission to Sycamore Chiropractic and Nutrition to treat my son or daughter or legal dependent. I understand that I do not have to be present with them for every visit.

I understand that I am responsible for all charges that are associated with treatment of the minor for whom I am responsible.

_____ _____

Signature of Parent/Guardian Date

New Patient Chiropractic Intake Form

Patient's Name _____ Signature _____

Today's Date DOB Age Gender M / F Height:_____ Weight:_____

Address _____ ☐ ☐

City _____ State _____ Zip Code _____

Marital status:_____ Email _____ Cell Phone _____

Emergency Contact

Name _____ Relationship _____ Telephone _____

How did you hear about our office? _____

Insurance Information

Policy holder's name _____ Policy holder's date of birth _____

Member ID _____ Group ID _____

Relationship of patient to policy holder ☐ SELF PAY

List in a few words the main issue you are having or the purpose for seeking care:

1. _____

2. _____

3. _____

Please rate your current pain level: Pain Free 0 10 Worst Ever

How long ago did your symptoms begin? _____

What seems to make you feel worse (certain movements, weather changes, etc.)?

_____

What seems to make you feel better?

_____

Please elaborate on your issue: (how would you describe the pain/issue, any treatment help)

Please list all medications and supplements you are currently taking:

Medication or Supplement	Dose	Frequency	Length of time taking it	Reason for taking it
Ex: Ibuprofen	***400 mg***	***2 X a day***	***1 week***	***Knee injury***

Current or past medical conditions (list date of diagnosis or onset) ☐ **NONE**

Accidents or Major Trauma / Injuries (list month and year) ☐ **NONE**

Surgeries/Hospitalizations (list month, year, reason) ☐ **NONE**

Family Medical History

List any major illnesses for each family member. If deceased, give cause of death and age at death.

Mother: _____

Father: _____

Maternal grandparents: _____

Paternal grandparents: _____

Brothers/sisters: _____

Frequency of bowel movements? ☐ 2-3x day ☐ 1x day ☐ Every other day ☐ 2x Week ☐ 1x Week

Average number of hours you sleep per night? ☐ >10 hours ☐ 8-10 hrs ☐ 6-8 hrs ☐ 4-6 hrs ☐ <4hrs

Do you have an excessive amount of stress? ☐ Yes ☐ No Are you happy overall? ☐ Yes ☐ No

Sleep position (select all that apply)? ☐ Back ☐ Belly ☐ Right Side ☐ Left Side ☐ Not sure

Hobbies and Leisure activities: _____

Please list anything else you would like us to know that was not otherwise covered: