Office Policy and Doctor's Lien

This document is to help simplify your understanding of our office policies and your financial responsibilities to our office.

___**MY RESPONSIBILITIES:** I understand that as a patient of the office of Neal Wieder, DC, DCBN, that I am ultimately responsible for all charges, services and products provided to me or any or all of my minor children (under the age of 18 If I am the Legal Guardian of a child or children under the age of 18 or an adult that is treated by Dr Neal Wieder and his staff. All unpaid balances that are 30 days past due, will be considered delinquent and may be subject to finance/service charges of 12% per annum. If any unpaid balance(s)not brought current and paid may be subject to collection proceedings and I will be responsible for any fees, collection costs, attorney fees, court costs, postage costs or any other costs involved in collecting a debt by this office. I agree to pay for copying & fax costs for records requested by my attorney or other parties. If I request FMLA forms, Disability or Life Insurance Forms to be filled out by Dr. Wieder I agree to pay their standard fees for this service.

___**INSURANCE**: I acknowledge and understand that the filing of insurance is a courtesy that the Office of Dr. Neal Wieder may extend to me to help pay for a portion of my medical expenses for services rendered by Dr. Neal Wieder and his staff. I further understand and agree to pay any and all individual or family deductibles, co-insurance, co-pays or any and all unpaid balances that are due and payable to Dr. Neal Wieder's office for services rendered to my family and I or a person I am legally responsible for. I agree to provide the office of Dr. Neal Wieder with all necessary insurance information and willingly shall complete all insurance carriers required insurance forms to help process my insurance claims. I also understand that there may be times when my insurance carrier's staff or internet services may provide incorrect insurance information to the staff of Dr. Neal Wieder in spite of all reasonable attempts to obtain correct and truthful insurance information about my coverage. I understand and agree to pay any unpaid balances due Dr. Neal Wieder in spite of this happening. If Dr. Neal Wieder is considered out of network by my insurance carrier I will be responsible for any and all unpaid deductibles, copays, co-insurances not paid for by my insurance carrier. Insurance is an agreement between myself and my carrier.

___**ASSIGNMENT OF BENEFITS:** I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Neal Wieder, DC DBA/Wieder Wellness Center for services rendered to me, or my minor child(ren) or any person I am a Guardian to by any and all insurance policies I am the insured of. This Benefit of Assignment shall remain in effect for one year from the date of this instrument.

___**RELEASE OF INFORMATION**: I hereby give permission to Dr, Neal Wieder and his staff to provide on my behalf any and all health information necessary to process insurance claims on my behalf for services rendered to me by Dr. Neal Wieder and his staff.

PAYMENT OF INSURANCE: I hereby appoint Neal Wieder, DC with the power of attorney for the sole purpose of endorsing, signing and receiving proceeds from insurance, other health benefits, settlement funds and third party claims related to services rendered to me by Dr. Neal Wieder and his staff.

___**MEDICARE PATIENTS (THIS PARAGRAPH ONLY APPLIES IF YOU ARE A MEDICARE PATIENT):** Medicare patients understand that only Chiropractic Spinal Manipulations (CPT Code 98940 or 98941) are allowable services payable by my Medicare insurance. Examinations, X-rays ordered by Dr, Wieder, therapies administered by Dr. Neal Wieder or his staff, vitamins and supplies are not reimbursable under my Medicare insurance policy and therefore are my financial responsibility. I understand and agree to pay for $226 deductible not met or paid, applicable co-insurances due and all services that are not paid to Dr Neal Wieder by my Medicare insurance or secondary insurance coverages for any reason. Our office only submits secondary billing for Medicare patients.

___**AUTO INJURY PATENTS:** I hereby agree to pay Dr. Neal Wieder any unpaid balances due his office for services rendered to me, or any and all uncovered services I have requested such as vitamins, supplies, acupuncture, or other services recommended to me by Dr. Neal Wieder while under his treatment..

___**LETTER OF PROTECTION AND DOCTOR'S LIEN:** I hereby direct my attorney of record to pay out of any settlement funds obtained on my behalf, or on behalf of my children or any adult I am.a Guardian for any and all remaining balance(s), late fees or interest due Dr. Neal Wieder for services rendered to my children or myself or any adult I am a Guardian for relating to my automobile/motorcycle/slip and fall/truck/school bus accident injuries. This Letter of Protection and Doctor's Lien supersedes any and all other documents I may have signed with my attorney of record or any other party involved in the settlement of my auto accident injuries that occurred on ____________.

If I change attorneys I agree to supply the office of Dr. Neal Wieder with the name, address and phone number of my new attorney. This document shall still remain in effect for my new attorney and their law firm and I direct my new attorney/law firm to honor this agreement.

Attorney Name/Law Firm:____

New Attorney/Law Firm____.

Dr. Neal Wieder remains an interested third party as it relates to my automobile accident that I am being treated for that the above attorney(ies) are representing me for in accordance with the State of Florida Bar Trust Account Rules.

___**WORKER'S COMPENSATION:** I understand that if I am claiming worker's compensation benefits, that in the event my claim is denied or payment is refused to be paid to Dr. Wieder for professional services rendered to me by Dr. Neal Wieder, I understand and agree to remain responsible for the payment of any and all services rendered or supplies recommend to me by Dr. Neal Wieder and his staff. Worker's Compensation usually pays up to18 visits if written authorization is sent to this office in advance. I agree to direct my attorney to pay Dr. Neal Wieder for any and all unpaid monies refused to be paid for my injuries.

___**CONSENT TO TREATMENT**: I hereby authorize and release Dr Neal Wieder and his staff to administer and or order chiropractic treatments, physical medicine modalities/or procedures, exams, lab tests, diagnostic testing, x-ray studies, acupuncture, laser therapy, recommend vitamin supplements, orthotics, food/eating plans or other supplies or exercises. I have been made aware of the risks and benefits of all recommendations that apply to my health care plan. I also acknowledge that I have disclosed in a truthful manner my health history to Dr. Neal Wieder or his staff.

______________________________	______________________________	____________
Printed Name of Patient/Parent/Guardian	Signature of Patient/Parent/Guardian	Date
______________________________	______________________________	____________
Printed Name of Staff	Signature of Staff	Date