DR. RENEE BONAREK
Doctor of Chiropractic
Certified Acupuncturist
(708) 625 - 6652
DrRenee@yahoo.com

OFFICE POLICIES

Insurance Verification
Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.

Deductible Payments
It is our policy to collect at time of service. Once we receive an "Explanation of Benefits" report form from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance
Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service. If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. Payment is due within 30 days of receipt of the bill. In the event a bill is disputed, you must notify use within 30 days. If you do not notify us within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days will accrue interest at the rate of 18% per annum. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us. All balances remaining unpaid after 30 days may be reported to a credit bureau and affect your credit rating.

Returned Checks
It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

Appointments
If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a $20 charge added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions
We are happy to address questions regarding you account at any time. Please direct accounting questions to the email address DrRenee@yahoo.com.

Designation of Authorized Representative
I do hereby designate Restore Health & Wellness to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Restore Health & Wellness. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

IRREVOCABLE Power of Attorney
I do hereby authorize Restore Health & Wellness to act on my behalf to pursue claims and exercise all rights in order to collect insurance payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Restore Health & Wellness.

AUTHORIZATION AND ASSIGNMENT
In consideration of your undertaking to care for me, I agree to the following:
1. You are authorized to release any information you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make direct payment to you of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, I personally owe to you.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to Restore Health & Wellness are paid in full.

_____

Signature Date