SEAY WELLNESS

INSURANCE GUIDELINES FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE IS COVERED FOR MUSCULOSKELETAL CONDITIONS ONLY & REQUIRES OUTCOME ASSESSMENTS TO BE PERFORMED AT INITIAL EXAM AND RE-EXAMS.

MEDICARE ONLY COVERS SPINAL ADJUSTMENTS (MANIPULATION) AND AN ADVANCED BENEFICIARY NOTICE OF NONCOVERAGE MUST BE SIGNED.

CHIROPRACTIC SERVICES ARE COVERED WHEN THE FOLLOWING CRITERIA ARE MET:

- It must be necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptoms.
- The patient has clinical symptoms of a condition that may be improved or resolved by standard chiropractic therapy.
- **A clear and appropriate treatment plan is documented, including symptoms/diagnosis being treated, diagnostic procedures and treatment modalities used, results of diagnostic procedures, treatments, anticipated length of treatments and quantifiable, attainable treatment goals.**
- The chiropractic diagnostic procedures, treatments are clearly related to the patient's symptoms/condition.
- Manipulation and modalities must be consistent with the patient's chief complaint, clinical examination findings, diagnoses and treatment plan.

CHIROPRACTIC SERVICES ARE NOT COVERED FOR THE FOLLOWING:

- Maintenance programs or supportive care**
- Low Level Laser Therapy
- Spinal Decompression Therapy
- Nutritional Supplements
- Dry Hydrotherapy (Aquamed)
- Services beyond benefit plan visit limitations or services that are excluded from the benefit plan
- Massage Therapy as a stand-alone treatment
- Kinesiology taping is considered investigational
- Laboratory testing and interpretation
- Metabolic Care (Lyme Disease, Thyroid, Fibromyalgia, ADD/ADHD, etc…)

CUSTOM ORTHOTICS ARE CONSIDERED ELIGIBLE (BCBS) WITH THE FOLLOWING CRITERIA:

- Foot pain/condition must be present.
- A non-custom orthotic must be used prior to custom orthotic.
- Medical necessity must be present and your benefits must include orthotics as a covered service.

Orthotics cannot be used for ankle, knee, or low back pain.

****Maintenance care is defined**: Elective healthcare that is typically long-term, not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or it may be initiated with patients without symptoms to promote health and to prevent future problems. This care may incorporate screening/evaluation procedures designed to identify developing risks or problems that may pertain to the patient's health status and give care/advice for these. Preventive/maintenance care is provided to optimize a patient's health. Maintenance begins when the therapeutic goals of a treatment plan have been achieved and when no further functional progress is apparent or expected to occur.

****Supportive care is defined as:** long-term treatment/care for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorates when there are periodic trials of treatment withdrawal. Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral, have been considered and/or attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care, or when risk of supportive care outweighs its benefit, i.e. physician/treatment dependence, somatization, illness behavior or secondary gain.

OUR OFFICE POLICIES REGARDING FILING YOUR INSURANCE:

- You will be responsible for all deductibles, co-insurance/payments, and non-covered services.
- We will do our best to accurately file your claims; however, we cannot be responsible for how your insurance chooses to reimburse for your care, even if it is different than the benefits they quoted to us.
- Should your carrier deny any claims, we will provide the necessary documents for reconsideration or for an appeal. You will be responsible for your account balance and for the pursuit of reimbursement from your insurance.
- If you care requires an authorization from your primary care doctor or insurance carrier, it is your responsibility to take care of this prior to your first visit with our office. We will not assume responsibility for any unauthorized treatment.
- It is important that you inform us of ALL insurance changes. This allows us to file claims in a timely manner and prevents billing errors.
- If for ANY reason your insurance company does not cover a visit, you will be responsible for payment of that service. Our billing department sends monthly statements. A $25 returned check fee will be charged for all returned checks, and payment to cover that check must be paid in cash, credit card, or money order.
- Our office does not hold accounts past 90 days. Neglected patient accounts are sent to a collection agency. Patients sent to the collection agency or filing for bankruptcy, causing our office to write-off any debt, are subsequently dismissed from the practice as well as all family members for whom the patient is responsible.

Patient non-compliance is a significant and contributory factor to poor treatment outcomes which can lead to more costly health care. Accordingly, it is the policy of this office to document non-compliance to treatment recommendations including but not limited to the frequency of treatment recommended in the patient's treatment plan.

Additionally, it is the policy of this office that services provided to patients who do not comply with this office's treatment plans/treatment recommendations will not be billed to their health care plans as such services are not consistent with "medically necessary care" and therefore, not covered by their health care plan. (This includes, but is not limited to, patients who do not keep scheduled appointments and/or choose to seek care at their discretion and/or at their convenience.)

I acknowledge that I am aware of these guidelines as set by my health insurance plan and understand the above policy. I acknowledge that I need to follow my treatment plan to the best of my ability as outline by Dr. Seay. I am aware that I must have objective findings to warrant filing my health insurance. If my objective findings normalize, I understand that I will have to be moved to maintenance care or supportive care.

Patient Signature: _____ Date: _____