Carey Chiropractic, P.A.
DR. MARISA CAREY
103 POPLAR ST., P.O. BOX A
FRUITLAND, MD 21826

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GROUP INSURANCE POLICY, STATE MEDICAL ASSISTANCE INSURANCE AND VOLUNTARY WAIVER OF HMO BENEFITS

CAREY CHIROPRACTIC ACCEPTS ASSIGNMENT WITH THE FOLLOWING INSURANCES: MEDICARE, AUTO (PIP) AND WORKMAN'S COMPENSATION.

IF YOU DO NOT HAVE THE ABOVE INSURANCES WE PARTICIPATE WITH, WE WILL COLLECT PAYMENT AT TIME OF TREATMENT AND WILL GRATUITOUSLY BILL YOUR INSURANCE FOR YOU. IF YOU HAVE NON-PARTICIPATING BENEFITS, YOU CAN TYPICALLY EXPECT PAYMENT FROM YOUR INSURANCE COMPANY BY MAIL WITHIN 2-3 WEEKS.

I, _____ (PATIENT NAME) AM SEEKING CHIROPRACTIC CARE FROM DR. MARIA L. CAREY OF CAREY CHIROPRACTIC, P.A.

CHECK ONE

_____I AM NOT A MEMBER OF A "HEALTH MAINTENANCE ORGANIZATION" (HMO) AND I DO NOT HAVE INSURANCE DR. CAREY PARTICIPATES WITH, SO I WILL BE RESPONSIBLE FOR THE PAYMENT OF ANY AMOUNTS OWED TO DR. CAREY FOR SERVICES PROVIDED.

_____I AM A MEMBER OF AN HMO BUT HAVE BEEN INFORMED THAT DR. CAREY IS NOT A PARTICIPATING PROVIDER WITH THAT HMO AND THAT IF DR. CAREY PROVIDES SERVICES TO ME, I WILL BE BILLED AT DR. CAREY'S USUAL RATE AND I, INSTEAD OF MY HMO, WILL BE RESPONSIBLE FOR FULL PAYMENT OF THAT BILL.

_____I UNDERSTAND THAT IF, INSTEAD OF RECEIVING TREATMENT FROM DR. CAREY, I HAD ELECTED TO OBTAIN TREATMENT FROM A HEALTHCARE PROVIDER PARTICIPATING IN MY HMO/GROUP INSURANCE/ STATE INSURANCE AND THE INSURANCE DETERMINED THAT THE SERVICE WAS COVERED UNDER MY BENEFIT PLAN, I WOULD BE ENTITLED TO HAVE THIS SERVICE REIMBURSED SET FORTH IN THAT PLAN.

THEREFORE, THIS MEANS:

1. I WILL BE SOLELY RESPONSIBLE FOR DR. CAREY'S CHARGES;
2. DR. CAREY WILL NOT SEEK PAYMENT FROM MY HMO/GROUP INSURANCE/MEDICAL ASSISTANCE INSURANCE.

I HAVE READ AND UNDERSTAND THIS POLICY

PATIENT NAME _____

DATE _____