HOLISTIC CENTER FOR Vibrant Health
Your Partners in Creating a Dynamic Life

Motor Vehicle Accident Office Policy

If you were in an auto accident please read the following:

There are certain ways to handle PIP coverage for your treatment in our office. The choices are clear and determined by your insurance coverage.

____ *(initial)* If you received treatment from a medical physician or medical facility within 14 days of the accident, you may be entitled to up to $10,000 in PIP coverage. If you did not, you may be entitled to only $2,500 in PIP coverage.

____ *(initial)* Our office will verify your car insurance policy. Florida is a **NO-FAULT** state. This means that regardless of fault, we file claims for treatment under YOUR car insurance policy.

There are two possible situations from the start: Your coverage is either 100% because there is Med-Pay on your policy, or the coverage is 80% due to no Med-Pay, up to the PIP coverage limit of $2,500 or $10,000.

___ *(initial)* If your policy is 80%, then you are responsible for the remaining 20% of your balance. You can handle the remaining 20% by:

a) Allowing an attorney to recover the balance at settlement.
b) Having the "at-fault" party's insurance pay for the 20%, if this is verified, and agreed upon before your treatment starts. Any treatment received before this is verified will require payment at the time services are rendered.
c) Filing with your group health insurance for reimbursement as policy permits. We will verify coverage at the time it becomes necessary. You will be responsible for anything not covered.

___ *(initial)* All of the choices are determined by your insurance policy. Insurance must be verified, and any **non-covered charges are your responsibility.**

___ *(initial)* You agree to do your best to adhere to the treatment plan Dr. Lisa Marsh sets for you, based on the initial exam, and assessments throughout treatment. If you choose not to adhere to the treatment plan and maintain the level to treatment recommended and agreed upon, Dr. Lisa may request a re-exam in order to complete your file.

I have read, understand and agree to the above information. I understand that any non-covered charges are my responsibility.

_____ _____
Patient Signature *Date*

_____
Print Patient Name

4/6/2021