Financial Policy and Agreement

This is an agreement between NeuroSpine Group, LLC, as Creditor and the Patient/Debtor named on this form. In this agreement the words “you,” “your,” and “yours” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are applied and payments credited. The words “we,” “us,” and “our” refer to NeuroSpine Group, LLC.

FINANCIAL RESPONSIBILITY. I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at NeuroSpine Group, LLC. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED. Self-Pay Accounts: A new patient deposit of $320.00 will be required at the time of service. For followup office visits, we will collect $140.00. These are only estimates toward the final amount billed by your physician. With these deposit amounts, we will honor a 30% discount on finalized charges, and any residual balance will be billed to the patient via a monthly statement. For surgery, deposits will be collected accordingly. If payment installments are needed beyond the initial deposit for services, NeuroSpine Group, LLC, does offer a 3-month or 6-month payment plan based upon the total account balance. **Arrangements outside of these parameters must be agreed upon prior to services.** Returned checks from your financial institution for insufficient funds will incur a fee of $35.00 on your account.

INSURANCE COPAY MUST BE PAID AT THE TIME OF SERVICE. Medical coverage is a contract between you and your insurance company. As a courtesy to our patients, we will submit your insurance claim for you. Obtaining precertification or authorization is NEVER a guarantee of payment by the insurance company. In addition to deductibles, coinsurance, and copays, pre-existing conditions or exclusions may require you to pay a portion or all of our charges.

Our business office will provide you with an estimate of the amount due based upon benefits verified with your insurance company. There are no guarantees that the amount due estimated at the time of service will be the final amount that you are responsible for paying to NeuroSpine Group, LLC. Please make sure you provide NeuroSpine Group, LLC, with accurate insurance information and a copy of your insurance card.

WORKERS’ COMPENSATION AND OTHER ACCIDENT COVERAGE. We require approval or authorization by your worker’s compensation or liability insurance carrier prior to your initial visit. We also require a written referral from the attending physician. If the reason for being seen is the result of an accident of any type, it is important that we know when and where the accident occurred, any attorney you have retained, and how you are planning to pay for your services. For any accident insurance carrier, including workers’ compensation and motor vehicle, we will obtain any health insurance coverage as a backup in the event of a payment denial or exhaustion of benefits. This is necessary in order to obtain any required prior authorization for services from the health insurance carrier. If your claim is denied, you will be responsible for payment in full. If you file a lawsuit that includes our charges as damages, you are still responsible for the full amount of our charges; however, if you notify us of the lawsuit and allow us to file a lien in the amount of our charges, we may, at our option, wait until conclusion of the lawsuit to collect our charges from the proceeds of the lawsuit.

ASSIGNMENT OF INSURANCE BENEFITS. You assign medical benefits paid by your insurance carrier(s), including Medicare benefits, for medical care rendered to you or to your dependents, to NeuroSpine Group, LLC. You authorize NeuroSpine Group, LLC to release any medical information required to process a claim with an insurance payer. You understand and acknowledge that, although NeuroSpine Group, LLC, may seek to secure payment for medical services provided to you from insurers or other third parties you identify, you are solely responsible for paying the full cost of all services provided. You acknowledge that you will be billed for charges not covered under your insurance policy as well as those charges indicated as your responsibility.

WAIVER OF CONFIDENTIALITY. If this account is submitted to an attorney or collection agency for the purpose of obtaining payments due, you consent to our using or disclosing protected health information relating to medical treatment received at our facility. We are permitted to refuse treatment if consent to disclosure for these purposes is refused. Consent may be revoked in writing at any time.

I have read, understand, and will abide by the Financial Policy and Agreement of NeuroSpine Group, LLC.

______________________________	______________________________
Signature (Parent / Legal Representative)	Date
______________________________	______________________________
Printed Name	Relationship to Patient

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