

Patient Financial Policy

Welcome to Neurosurgical Spine Institute. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. Please read carefully the Financial Policies as described below.

Payment of Services:

Payment for services rendered is ultimately the patient's responsibility. Your insurance is a contract between you and your insurance company; it is your responsibility to give us the correct informations about your insurance plan. If you cannot provide a current medical insurance card/policy, full payment must be made at the time of service. .

Co-Payments and Deductibles:

Your insurance company requires you to pay your co-pay, deductibles and co-insurances at the time of service. We cannot waive co-payments, deductibles or co-insurances. We make every effort to follow the guidelines required by your insurance company. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service that is denied, we have no choice but to bill you directly for those charges.

Collection Policy:

If you have an outstanding balance, we will mail you a statement monthly. Failure to pay your portion of insurance allowable is a violation of your insurance contract. If you default on your promised payment, our policy is to refer to a collection agency. The balance will accrue an additional fee for the expenses related to collections. Checks returned to our office for non-sufficient funds will incur a \$30.00 service charge.

Cancellation/Missed Appointments:

Patients are seen by appointment. If you cannot keep your appointment it is your responsibility to call at least 24 hours in advance. Patients that do not show/miss their appointments will be charged \$50.00 for that missed appointment. After three no show appointments; it is at the practices discretion to dismiss the patient for non-compliance.

Our staff will be happy to answer any questions you may have about our policies.

I have read and understand the terms of this Financial policy. I understand and agree that such terms may be amended from time to time by the practice. I agree to assign insurance benefits to Neurosurgical Spine Institute. I authorize the release of medical information to my primary and referring physician, and/or consultants if needed and as necessary to process insurance claims, insurance authorizations and prescriptions.

X _____ Date _____