NAME:_____**#**_____ **DATE:**_____

FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing NeuroSpinecare, Inc. for your medical treatment. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. We have provided this policy to you to ensure that you are aware of your financial responsibility and to provide you the opportunity to ask questions regarding our policy.

Our office will make every effort to collect any insurance portion which is required by your policy. However, it is your responsibility to provide our office with correct information at the time of your appointment. A copy of your insurance card will be made and we will submit the information necessary to your insurance plan. If you do not have your financial information at the time of service, you will be considered Self Pay and will need to make payment at that time. Please read the different types of Patient classifications and provide the information which pertains to you.

Medicare: Our office accepts Medicare Assignment. You are responsible for any balances due after the Medicare payment.

Medicaid: All Medicaid patients must submit their identification card at every visit. You are responsible for any spend down amounts and any services provided on dates that you are not eligible.

BWC (Workers Compensation): Please provide us with the name of your employer, the date of injury and the allowed diagnosis for your claim. If you do not have this information at the time of service, you will be considered ***self Pay*.***

HMO Plans: Patients with HMO plans require referrals from the (PCP) Primary Care Physician. We must have this referral prior to being seen by our doctor.

Commercial Health Plans: We will submit your insurance claims for you and you will be billed for any coinsurance amount.

Self Pay: Patients who do not have insurance coverage or choose to have a third party involved in payment of medical care, are expected to make payment at the time of service and will be given a receipt.

COPAYS- Co pays are due at the time of the visit.

BILLING- Billing statements are sent monthly. Payments are due within 30 days. The expected payment schedule is as follows:

Balance under $100.00 - Payment in full required

Balance $100-$400 - Payment of at least 50% of balance required monthly

Balance over $400 - Payment of at least 20% of balance required monthly

Accounts delinquent more than 60 days will require that payment arrangements be discussed with the Billing Department prior to scheduling further appointments.

METHOD OF PAYMENT- We accept Cash, Check, Visa, MasterCard and Discover.

RETURNED CHECK FEE – There will be a $10.00 fee added to your account if a check is returned by the bank.

NO-SHOW FEE- We reserve the right to charge for patients who do not allow for 24 hour notice for cancellation of their appointment.

Please sign and date this form, acknowledging that you have read and understand our financial policy.

_____ _____

Signature **Date**

NeuroSpinecare, Inc. 440-930-6015
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