Atlas
Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

Financial Policy

Atlas Neurosurgery and Spine Center is committed to serving our patients with professionalism and care. Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Atlas Neurosurgery and Spine Center will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you. For services performed outside of our clinic, i.e. radiology, laboratory, referrals, surgery centers, physical therapy, hospitals and rehabilitation centers, please consult your insurance prior to scheduling.

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities. This is a legally binding contract between Atlas Neurosurgery and Spine Center and you. The words, I, me, my, you and your refer to the patient.

_____ (initial) I agree to be financially responsible for payment of Atlas Neurosurgery and Spine Center services. Cash, check or credit cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. Atlas Neurosurgery and Spine Center is not responsible for filing your insurance claim, but we will do so as a courtesy. Upon payment from my insurance carrier, I agree to pay the remaining balance immediately.

_____ (initial) I agree to give Atlas Neurosurgery and Spine Center my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that a failure to provide complete and accurate information about my insurance benefits may result in a denial of my claim or a delay in payment. I agree to pay the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will have to pay the estimated charges for my office visit in advance.

_____ (initial) I understand that I will be responsible for any missed appointments or any cancelled appointments where a 48-hour notice was not provided. There will be a fee of $50 for any missed office visits and $250 for any missed surgical procedures.

_____ (initial) I understand that all services provided to me by Atlas Neurosurgery and Spine Center are considered medically necessary. If I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance payment has been processed.

_____ (initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved in advance. In such a scenario, I agree to pay the balance remaining on my account.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) Atlas Neurosurgery and Spine Center will receive payment from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

_____ (initial) I understand and agree that if my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

I have read and understand these financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature Date

Abhishiek Sharma, MD
Erik Curtis, MD

Atlas Neurosurgery & Spine

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Atlas Neurosurgery and Spine Center. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary in order to obtain payment. I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges incurred during the process of settling my account. I understand that I am solely responsible for all charges during a lapse in insurance or lack thereof. I authorize Atlas Neurosurgery and Spine Center to deposit checks received on my account when made out in my name.

I have read and I understand these financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

CREDIT CARD ON FILE POLICY

At Atlas Neurosurgery and Spine Center, we require a credit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $50 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 5% of the total bill will be charged for each month that the balance remains unpaid.

Your credit card information is kept confidential and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account unless requested by you.

I authorize Atlas Neurosurgery and Spine Center to charge the portion of my bill that is my financial responsibility to the following credit card:

Atlas
Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Atlas Neurosurgery and Spine Center to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Atlas Neurosurgery and Spine Center.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Atlas Neurosurgery and Spine Center in writing and the account must be in good standing.

_____ _____

Patient Signature Date

Atlas
Neurosurgery & Spine

Abhishiek Sharma, MD
Erik Curtis, MD

NOTICE TO PATIENTS

A physician must notify a patient that the physician has a direct interest in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). We support this law because it helps patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of this law, you are being advised we have a direct interest in the diagnostic or treatment agency or in the non-routine goods or services named below:

Dr. Sharma has medical consulting agreements with Medtronic, A-tec and Johnson & Johnson. He also has a direct financial interest with Banner Health and Scottsdale Healthcare Hospitals D/B/A HonorHealth whereby the hospital shares with the physicians a portion of the savings attributed to quality enhancement and cost savings arrangement. These arrangements include spine implants, biologics and spine ancillary products.

Dr. Curtis has a direct financial interest with Banner Health and Scottsdale Healthcare Hospitals D/B/A HonorHealth whereby the hospital shares with the physicians a portion of the savings attributed to quality enhancement and cost savings. These arrangements include spine implants, biologics and spine ancillary products.

Multiple other health care companies offer the same equipment that may accomplish the goals of the equipment provided by the above health care companies listed. You are encouraged to ask any of our physicians their reasons for choosing instruments from the above listed companies, or any other instrument, in your treatment. The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file and you may request a copy.

I hereby give my consent for photography, filming, videotaping and/or audio recording or other means of capturing my image, radiographic or otherwise, or voice and/or being quoted in the media or printed materials (including social media websites) at Atlas Neurosurgery and Spine Center. I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold Atlas Neurosurgery and Spine Center and its personnel and affiliated programs harmless from any and all liability which may or could arise from activities authorized by this agreement. I may request cessation of such use or rescind this Authorization up until a reasonable time before use, but I must do so in writing. I have a right to receive a copy of this Authorization.

_____ _____

Patient Signature Date