

Your Financial Responsibilities

Our office will file your insurance for all services rendered, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, negotiated out of network, and non-covered service amount. We accept payment by cash, check, money orders, Visa, MasterCard, American Express and Discover Card. You will receive statements from our office for account balances that are your responsibility; the balance is due **15 days** from when your insurance pays your claim. If the patient portion of your account is not paid in a timely manner your unpaid patient portion balance will accrue 18% interest and collection efforts will be made. Any Collection agency and or attorney fees incurred to collect the patient portion of your account will be at your expense.

SELF-PAY patients: On your first initial office visit, All Self-Pay patients and patients who present without proof of insurance are required to pay \$550 at the time of visit with check, cash, money order, or credit card at the time of service. All subsequent visits are to be paid at the time of service.

PPO, POS and HMO plans that we contract with: We will submit your claim to your insurance carrier. If the services you receive are covered by the plan you are responsible for all applicable co-pays and deductibles. Your insurance **REQUIRES** that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit. **Without it, you may be required to reschedule.** If the services you receive are not covered by your plan, payment in full is required.

PPO, POS and HMO plans that we not contract with (out of network): We will submit your claim to your insurance carrier. As a non-participating provider your insurance company will not always reimburse us directly for services rendered. Therefore, it is your responsibility to forward the original check, explanation of benefits and/or any type of correspondence from your insurance company immediately to our office. For your office visit and physical therapy, as long as you have out of network benefits, we will accept what your insurance pays minus your office co-pay and any deductible that has been applied to your visit. Surgeries and Procedures are negotiated with you and a financial counselor will discuss with you your financial obligation regarding the proposed surgery/procedure.

If your insurance company utilizes a network that we are contracted with, for example: Beech Street, TRPN, Cigna, etc., we must abide by our contract with that network and you will be responsible for your percentage of the allowable amount.

MEDICARE: You will be responsible for any portion of your deductible that is not paid or covered by your secondary insurance. You will be responsible for any service not covered by Medicare. If you do not have secondary insurance you will be responsible for the 20% co-pay. All patient balances remaining after Medicare and secondary payment will be billed to you and will be due within **15 days** of the billing statement.

ACCIDENT/WORKERS COMP CASES: Patient shall be financially responsible for medical services related to accident/workers comp if you fail to notify the South Florida Spine Clinic in advance of an accident/workers comp injury. You will need to supply us with a date of injury, claim#, insurance company address, phone number and contact person's name prior to coming to the office and sign separate Financial Agreement with your workers comp adjuster or a Letter of Protection with your attorney, if applicable. If they do not pay, due to any circumstances not related to your case and or accident, the patient is responsible for payment.

RETURNED CHECK FEES: Any returned check from the bank for non-payment or insufficient funds shall result in the patient's account being assessed a \$35.00 fee per check returned.

OUTSTANDING BALANCES: If you have any outstanding self-pay or insurance designated outstanding balances for co-pays, deductibles, negotiated fees for out of network balances and the like, and you have been billed more than 30 days without payment, you will accrue an 18% interest charge on your account and will be sent to collections for further debt collections, any applicable fees associated with collections and attorney fees will be at your expense.

I have read the Financial Policies of The South Florida Spine Clinic and agree to comply with the Financial Polices. In addition, The South Florida Spine Clinic has my permission to provide medical documentation in order to obtain reimbursement.

Patient Name (Print Please)

Date

Patient (or Representative Guardian Parent) Signature

Date