SPINE AND ORTHOPEDIC SOLUTIONS

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FINANCIAL POLICY

Thank you for choosing Spine and Orthopedic Solutions as your healthcare provider. We are committed to providing you with the best available medical care. In our ongoing process to make sure all of your medical needs are met, our staff will be available to discuss our fees and this policy with you. The services you have elected to participate in imply a financial responsibility on your part.

Payments for all services will be due at the time the services are rendered. In order to better serve you, we accept cash, check, Visa, MasterCard, Discover and American Express. As a courtesy to you, we will verify your coverage and bill your insurance carrier on our behalf; however, you are ultimately responsible for the entire bill. As the responsible party, please understand:

(PLEASE INITIAL THE FOLLOWING)

_____ Your insurance policy is a contract between you, your employer (if applicable) and your insurance provider. Spine and Orthopedic Solutions is a party to that contract. Our relationship is to you, not your insurance provider. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance or “usual and customary” charges. As your medical provider, we will only supply factual information to facilitate claims processing.

_____ I understand that I may have an insurance plan that restricts my therapy either by units or by a payable dollar amount ant that is my financial responsibility for the difference between services covered by my policy and the actual services provided.

_____ Fee for services, which include unpaid balances, deductibles, co-payments and coinsurance, are due at the time of service. I understand should I receive therapy, a co-pay will be due at the time of service for each visit. I understand and agree if I fail to make payments for which I am responsible within three statement billing cycles, after such default and upon referral to a collection agency or attorney by Spine and Orthopedic Solutions, I will be responsible for all costs of collecting monies owed including collection agency fees.

_____ All charges are my responsibility. If my insurance carrier does not remit payment within sixty days, the balance may be due in full form from me. IF any payment is made directly to me for services billed by Spine and Orthopedic Solutions, I recognize an obligation to promptly remit payment to Spine and Orthopedic Solutions.

_____ I understand should I incur a balance that I am unable to pay within three billing cycles, I am required to contact Spine and Orthopedic Solutions to set up a payment plan.

_____ Completion of disability and/or FMLA forms are not billable/reimbursable by insurance carriers, therefore, fees are my responsibility for payment. Spine and Orthopedic Solutions fees related to completion of these documents are expected to be paid upon presentation of forms for completion.

_____ Returned checks and unpaid balances may be subject to collection placement and a collection fee for first placement and if legal action is required. I will be responsible for all costs of collecting monies owed including processing fees.

_____ Spine and Orthopedic Solutions utilize the services of Assistant Surgeons/ Physician Assistants/Nurse Practitioners for all medical services, including surgical procedures. We will bill your insurance for these services; however, should your insurance deny the charges as a non=covered you will be held ultimately responsible.

_____ I give consent to be contacted by my provider and their Designated Business Associates through any medium, including but not limited to wireless cell phone, email, and landline telephone, By providing your cellular number you are agreeing to be3 contacted by the provider and any entity working on the provider’s behalf at that cellular number, and if necessary by an automated dialing or messaging system.

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We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

We understand financial problems may affect timely payments, so we encourage you to communicate any such problems, so we may assist you in keeping your account in good standing.

_____ _____

Printed Name of Patient: Signature

_____ _____

Relationship to Patient Date