# PATIENT FINANCIAL POLICY

Thank you for choosing NeuroSpine Center of Wisconsin (NeuroSpine Center) as your health care provider. While your health and well-being is our primary concern, we realize that the cost of healthcare is a concern for our patients. We offer the following information to help you understand our financial policies and aid you in planning for payment. Carefully review the information and please ask if you have any questions.

**Insurance:** It is your responsibility to provide NeuroSpine Center with current insurance information. We will ask for your insurance card at your first visit and keep a copy for our records. We may occasionally request a copy at a later date in order to update your records, so please bring your current insurance card with you every time you visit our office.

We will help you receive the maximum benefits your insurance allows. However, please remember that your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you, but we will not become involved in disputes between you and your insurance carrier. In order to properly bill your insurance company, you agree to provide us with all insurance information, including primary and secondary insurance, as well as any changes in insurance information. Failure to provide complete insurance information may result in you being responsible for the entire bill.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that they will not cover. Your insurance company makes the final determination of your eligibility and benefits. In the event that your health plan determines a service to be "not covered," you may be responsible for the entire charge. Also, please be aware that if we are out of network for your insurance carrier, your share of our charges is typically more than if we are in network.

Once your insurance company has processed your claim, and you and NeuroSpine Center have received an explanation of benefits, we will bill you for any remaining balance that is your responsibility. This balance is due upon your receipt of our statement. In the event that you are unable to pay the balance in full, we encourage you to contact our Business Office promptly for assistance in arranging reasonable installment payments.

**Co-pays:** Co-payments may be required by your insurance plan. All co-payments must be paid when you check in at our front desk prior to your appointment. If you do not have your co-payment, your appointment may be re-scheduled.

**Self-pay Accounts:** Self-pay accounts are for patients without insurance coverage. It may also include patients covered by insurance plans in which NeuroSpine Center does not participate or patients without an insurance card on file with us. It is your responsibility to know if NeuroSpine Center is participating with your plan. If there is a discrepancy with our information, you will be considered self-pay until you provide information proving otherwise.

Self-pay patients are required to pay a deposit toward estimated charges prior to the first appointment (currently $300, subject to change), prior to each follow-up or physical therapy appointment (currently $130, subject to change), and prior to each injection appointment (approximately $1,500, depending on

the injection, subject to change). If these deposits should result in a credit balance, we will refund the overpayment to you. If a surgery is recommended, we will work with you to determine reasonable payment arrangements prior to the surgery date.

**Past Due Accounts:** If your account is referred to a collection agency or attorney, you agree to pay all of the collection costs, including attorneys' fees and court costs. Accounts referred to a collection agency or attorney may be reported to the Credit Bureau.

If your account becomes past due, any upcoming appointments may need to be postponed until your account is made current. If your account has been referred to a collection agency or attorney, you must pay the balance in full, including any collection fees, before an appointment will be scheduled, and you may be required to make the same up-front payments as required of self-pay patients (as detailed above), regardless of any insurance coverage. It may also be possible that our physicians and other health care providers will no longer be able to provide your care. In this case, you will be notified by certified mail and given adequate time to find a new medical provider.

**Returned Checks:** You may be assessed a fee for a returned check (currently $30, subject to change). This amount will be applied to your account in addition to the insufficient funds amount. Your account may be assigned "self-pay" status, requiring up-front payments, following a returned check.

**Referrals and Pre-authorizations/Pre-notifications/Pre-certifications:**
Your insurance company may require a referral from another physician and/or a pre-authorization/pre-notification/pre-certification. While it is your responsibility to obtain these, we will help you. Please be aware that while a referral and/or a pre-authorization/pre-notification/pre-certification may be required by your insurance company, having a referral and/or pre-authorization/pre-notification/pre-certification does not guarantee payment by your insurance company. However, failure to obtain these may result in a lower payment or no payment from your insurance company and the balance will be your responsibility.

**Workers' Compensation and Automobile Accident Accounts:** In the case of an on the job or automobile accident injury, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If you do not provide this information, your appointment may be re-scheduled to another time when you will have the information or your account may be assigned self-pay status, requiring up-front payments. We do not accept attorney letters or contingency payments and we do not bill any third parties.

**Appointments:** To best serve all our patients, we kindly ask for 24 hours' notice if you are unable to keep an appointment. Appointments missed or not cancelled with at least 24 hours' notice may be assessed a charge (currently $25, subject to change). This charge is not covered by insurance.

Please help us best serve you and our other patients by being on time for your appointments.

**Minors:** The parent(s) or guardian(s) presenting the child for treatment is responsible for full payment and will receive the billing statements. In addition, we may pursue payment from a non-custodial parent or guardian.

***[Signature on next page.]***

PATIENT AUTHORIZATION, ACKNOWLEDGEMENT, AND AGREEMENT

**I hereby authorize payment of health insurance benefits (and, if applicable, government benefits) directly to NeuroSpine Center for services furnished to me. I authorize the release of any of my healthcare information necessary to process my claims. I further authorize the release of my healthcare information to other health care providers, hospitals, and facilities involved in my treatment.**

**I understand, acknowledge, and agree that I am financially responsible for my deductible, co-pay, co-insurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, and pre-authorizations.**

I HAVE READ THE ABOVE PATIENT FINANCIAL POLICY AND/OR IT HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS, AND THAT I AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Print Patient's Name: ___________________________________________ Date: ____________

Signature: _______________________________________________________________________

If Legal Representative, provide relationship to Patient: _________________________________

Witness Signature: ________________________________________________________________