ORTHO SPINE AMERICA

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STATEMENT OF POLICIES

Providing excellent orthopedic care to our patients - regardless of insurance coverage - is something we are committed to, so please read this information carefully before signing and ask the receptionist if you have any questions.

ALL INSURANCE POLICY HOLDERS

Our business relationship is with our patients, not insurance companies; however, the insurance carriers have considerable influence in this relationship. In order to file a claim with your insurance company, we must have valid insurance cards on file. It is the patient's responsibility to update our staff on any insurance changes at every visit. If current insurance information is not given to our office, you will be responsible for payment in full for any services rendered on that day.

We will file your claims with your insurance companies. All charges incurred are your responsibility if your insurance company chooses not to pay for any reason. It's important for you to read your policy handbook and to understand which services may be considered "not medically necessary." The physician may perform services that fall within this category, and this does not relieve you of the financial obligation.

Any co-pay required by an insurance company must be paid in full at the time of service. Because this is an insurance requirement, we cannot bill you for this co-pay. If you are unable to pay your co-pay, you may be required to reschedule your appointment. Any previous balance is expected to be paid at the time of service.

If you are unable to keep a scheduled clinic appointment, please call during normal business hours, 24 hours in advance, to cancel the appointment. There will be a charge of $25.00 for no-shows & cancellations within the 24-hour period.

MEDICARE PATIENTS

Secondary insurance will be filed by this office, if we have a contract with your insurance, as a courtesy. If your secondary insurance is out of network, the remaining 20% will be due at the time of service. If the secondary amount remains unpaid by your insurance after 60 days, the unpaid balance will become your responsibility.

UNINSURED OR OUT OF NETWORK PATIENTS

If our practice does not have a contract with your insurance company, or if you are an uninsured patient, you (or responsible party for minors) are responsible for payment in full at the time the services are rendered. There may be a need to arrange a payment plan for any elective surgical procedure at the time the procedure is scheduled. Customarily, our policy requires 50% of the surgeon's fee paid prior to scheduling.

PRESCRIPTION POLICIES:.

If you are in need of a refill, please call the office phone during normal business hours, which are M-Th 8am-5pm. Please allow up to 48 hours to process the request. Replies to requests will only be called in during normal business hours. No refills will be called in after 5pm on weekdays, or on the weekends.

RETURNED CHECKS

Any returned check will be subject to a $35.00 service fee. This will need to be resolved before any future treatment is scheduled.

PAPERWORK

There is a $15.00 charge for any additional paperwork unassociated with your health insurance. Examples: disability forms, FMLA forms, work stats notes, etc. There is a fee for any reports or records requested by attorneys, insurance companies, disability companies, etc. The charge will be determined by the information requested.

There is a charge to have X-ray & MRI images copied. This fee is $10.00 for a disc.

SUPPLIES

All supplies are non-returnable/non-refundable.

Please be sure you want the supply offered before you take the item from our office. Your insurance may not cover the cost of the supply (depending on the provisions of your policy). Supplies may also be purchased from other vendors, but this office cannot be responsible for fitting/adjusting these items. Please ask the reception desk if you have questions about the cost of the supply item.

I acknowledge that I have carefully read and understand the statement of policies and agree to abide by them.

Name (please print) - Parent name if patient is a minor _____

Date of Birth _____

Signature _____ Date _____