Financial Policies and Procedures

The Spinal Health and Wellness Center, LLC is dedicated to providing the highest level of care to our patients. In order to provide high quality care, we must be able to meet the expenses necessary to operate our facility. Please sign and date this Financial Policies and Procedure Agreement to indicate that you accept these terms.

Payment of Time of Service, Fees and Collections:
It is important to remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to understand your insurance coverage. It is advised that you call the phone number on your insurance card to verify your benefits. We verify insurance benefits and file insurance claims as a courtesy to you. However, you are ultimately responsible for payment of services provided by our office.

You are responsible for any amounts that are not covered by your insurance company. We require that you pay any deductible amounts, co-insurance amounts and copays on the day of service. If a claim is rejected because your insurance company does not cover the type of service, you will be responsible for the cost of that service. We will provide you with a statement in these cases. We expect payment on these statements within 30 days. If your account is past due, your account may be turned over to a collection agency. If your account is placed into the collection process, collection fees will be added to your balance. Spinal Health and Wellness Center, LLC, reserves the right to terminate any patient if their account becomes delinquent. By signing our financial policy, you agree to pay these added fees, along with any and all costs associated with the collection of your account, including interest charges.

Payment Options:
Our office accepts credit cards, debit cards, cash and checks for payment. There will be a $50.00 fee for all returned checks. Please speak to the Front Desk about these accounts.

Medicare Patients:
If Medicare is your primary insurance, and you do not have a secondary insurance, you are responsible for the deductible, co-insurance and copays at the time of service. You are responsible to pay for services not covered by your Medicare insurance policy, unless you have a secondary insurance. You are also responsible for any services not paid by your secondary insurance. You will be required to sign an Advance Beneficiary Notice for all non-covered services.

Non-Contracted Insurance:
If you have an insurance plan that we do not participate with, you will be considered a self-pay, uninsured patient.

Missed Appointment/No Shows/Late for Appointment:
We understand if you cannot keep all of your scheduled appointments or if you are occasionally late to an appointment. Please understand that missed appointments have a

detrimental impact on our practice and on our other patients. Missed appointments affect our ability to schedule other patients who are in need of medical care. If you must cancel or reschedule an appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule your appointment at least 24 hours in advance will be considered a No-show appointment. *We reserve the right to charge you and you agree to pay a fee of $40.00 for any No-show appointments.*

If you are running late on the date of your appointment, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. If you are more that 15 minutes late for any appointment, we may be forced to reschedule your appointment, and we will not be able to see you at your originally scheduled time.

Authorization to Release Information:
I hereby authorize Spinal Health and Wellness Center, LLC:

1. to release any information necessary to insurance carriers regarding my treatment
2. to process insurance claims generated during the course of my examination or treatment
3. to allow a photocopy of my signature to be used to process insurance claims for all services provided to me by Spinal Health and Wellness Center, LLC

This order will remain in effect until revoked by me in writing.

_____
Patient Name (PRINT)

_____
Name of Person Financially Responsible (PRINT)

_____ _____
SIGNATURE DATE
Person Financially Responsible for Patient's Treatment