



SPINE & SCOLIOSIS SPECIALISTS

ADVANCED TREATMENT & SURGERY

2105 Braxton Lane, Suite 101 • Greensboro, NC 27408

Phone: (336) 333-6306 • Fax: (336) 333-6309

Financial Policy

Welcome to Spine & Scoliosis Specialists. Thank you for choosing us as your healthcare provider. Our main concern is that you receive the proper and optimal care needed to maintain/restore your health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to contact our billing staff.

If you need to cancel an appointment, we ask for a 24-hour notice. If notice is not given, we do reserve the right to charge you for your missed appointment. We also reserve the right to dismiss you from the practice if you have cancelled or rescheduled three visits.

Please present your current insurance ID card at your visit and, if anything changes, we ask that you contact us immediately. In the event we do not participate with your insurance plan, you will be responsible for the entire bill.

As a service to you, our office makes every reasonable effort to obtain payment according to your coverage. Regardless of the type of insurance you have, you are ultimately responsible for paying your medical bills. If your insurance company rejects the claim or denies payment, the office will bill you for the entire amount. It is, at all times, your responsibility to follow up on all requests from your insurance company regarding claims and to question your insurance company about any unpaid claims. Failure to provide necessary referrals and/or authorizations will result in all charges for services becoming the sole responsibility of the patient/responsible party.

All co-payments and deductible amounts are due and should be paid at time of service. This policy is in accordance with legal requirements for collecting patient responsibility amounts. Our staff will inform you of these amounts prior to your procedure. Unresolved balances may be placed with an outside collection agency and may also be subject to finance charges, attorney fees and collection agency fees, which will be owed in addition to the remaining balance. If a balance remains unresolved, you may be dismissed from our practice.

If you do not have insurance and are considered self-pay, a minimum of \$260.00 or the actual charge, whichever is less, is due at the time of service. Any subsequent visit charges will be due at the time of service. If you cannot pay in full, you will need to set up a payment plan with our billing department.

A \$25.00 fee will be charged for all checks that are returned to us by your financial institution and will be payable immediately.

Our practice accepts Visa, MasterCard, HSA debit cards or Care Credit for your convenience. We also accept personal checks and cash. We will ask you for your co-payment at time of service. If you are unable to pay your co-payment, we will need to reschedule your appointment.

Authorization: I agree to abide by the terms of the above financial policy and accept responsibility for any balance not covered by my insurance company(s). I authorize my insurance company(s), attorney or other parties to pay Spine & Scoliosis Specialists and/or provide any information regarding payment of my bill. If my account becomes delinquent, I agree to pay all costs incurred in collection of the account, including any necessary collection and attorney fees.

I authorize Spine & Scoliosis Specialists to administer medical care as is necessary, including allowing release of records or medical reports on my condition to any party involved in my treatment.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____