Financial Policy

Thank you for choosing Axis Spine PLLC as your health care provider. We are committed to the successful treatment of your condition. Your clear understanding of our Financial Policy is important to our relationship. Please call our billing department if you have any questions.

- All patients must complete our Patient Registration Forms
- For cases which we bill insurance directly, we must have a copy of your Insurance ID card(s).
- For cases where we bill a third party (WC/Auto), we require a copy of your private Insurance ID card(s) for our records.
- Insurance Co-Payment is due at time of service.
- We accept cash, check, or credit card (Visa or MasterCard)

INSURANCE (PPO/POS/Commercial/Medicare Advantage Plans)

All co-payments are due at the time of service. We are members of most, but not all, plans. You are responsible for verifying that we are providers for your plan. If we are not contracted providers for your plan, you agree to pay patient responsibility charges for claims processed as "Out of Network". You are responsible for co-payments, deductibles and co-insurances on your plan. We maintain the right to collect payment towards patient responsibility prior to any high cost treatment (Surgery, MRI, other). If applicable, you will be directed to speak to a patient representative. You are responsible for any service denied by your insurance as a non-covered service.

HMO INSURANCE

All co-payments are due at time of service. You are responsible for providing the referral for your visit. We will assist with referrals for surgery and other services as directed by your plan. If you are an HMO member, you will not be billed additionally as long as we have the necessary referrals.

MEDICARE

We do accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between the approved amount and the amount that Medicare pays, and of course, your deductible. If you have supplemental insurance, please provide a copy of the card and we will bill it for you. You will receive a bill after your insurance has paid if there is any remaining balance.

SELF PAY

Payment is due in full at the time of service. If you are unable to pay your balance in full, you must see a patient representative to make other arrangements.

WORKERS' COMPENSATION

If you are being seen here as a result of work related injury, you must notify our staff **prior** to your appointment. We will require information regarding both your Workers' Compensation insurance and your private health insurance. We must obtain treatment authorization prior to your visit. If authorization for treatment under Workers' Compensation is denied, as a courtesy we will bill your health insurance carrier. If payment is not received from these parties, we have a right to bill you directly. If you have obtained an attorney, we will need the name, address and phone number for our records.

AUTO ACCIDENT CLAIMS

If you are being seen as a result of an auto accident, you must notify our staff **prior** to your appointment. We require both your Auto Insurance information and your private health insurance. If payment is not received from these parties, we have a right to bill you directly. If you have obtained an attorney, we will need the name, address and phone number for our records.

TREATMENT FOR A MINOR CHILD

A parent or legal guardian must accompany patients who are minors (under 18 years of age). This accompanying adult is responsible for payment of the account, according to policy outlined above.

RETURNED CHECK

A $35.00 charge will be added to your account for any check returned by your bank for any reason.

DISABILITY or INSURANCE FORMS

There will be a charge of $30.00-$50.00, depending on the complexity, for the completion of medical/disability/FMLA forms. Payment is due before paperwork is processed. Please allow 7-10 days for completion of these forms.

NO SHOW POLICY

You will be charged $50.00, if you were scheduled for an appointment in our office, but you did not attend the appointment and did not provide advanced notice of cancellation to our clinic

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

_____

Name of Patient (please print)

_____

Signature of Patient or Responsible Party Date

DOB: DATE