Name:_____ DOB:_____

FOUNDATION
PAIN & SPINE

Financial Policy & Assignment of Benefits

Our financial policy outlines our practice guidelines which should allow you to receive all the benefits offered to you by your health plan. We ask that you read the following carefully and agree to our terms and conditions to which are necessary to facilitate your care.

- Insurance cards should be available upon request at all visits.
- We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance companies and the member.
- Any dispute for unpaid charges from the insurance company will be billed to you the patient.
- **All copays, coinsurance & deductibles must be paid at the time of service, this is an insurance requirement and part of your contract with the insurance company.**
- **Contract –** Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. We are not a party to that contract. It is important that you understand the provisions of your policy, as we cannot guarantee payment of claims. In the instance your insurance company denies payment for services provided you are responsible for payment of treatment
- **Procedures & Injections Costs –** In all cases we collect an **estimate** of your financial responsibility amount at the time of service. Procedures & injections may be rescheduled if the estimated amount is not paid on or prior to the time of service. This will be an estimate ONLY and may be subject to change depending on the services provided. We will either bill you for the remaining balance or credit any overpayment in a timely manner. Payment plans are available upon request, please contact us PRIOR to your appointment. Unless you make prior arrangements, our financial policy will stand.

Charges and Fees

- **Charges for Forms -** Our charge for completing FMLA, Disability or Life Insurance paperwork is $35.00 per form and is due in full before the paperwork can be picked up, faxed or mailed. Allow 7-10 days processing. **No Show Fees -** We require 24-hour notice for appointment cancellations. In the event you do not give the required notification a no-show fee will be assessed. Office visits will incur a $25.00 fee and procedures/injections will incur a $100.00 fee. Patients who habitually fail to keep appointments may be discharged from our clinic.
- **Returned Checks -** A $25.00 fee will be charged for any returned checks and we will no longer accept your checks.
- **Payment Methods –** We accept cash, checks (Under $100), money orders and all major credit cards (VISA, Mastercard, Discover & American Express)
- **Account Billing Questions & Refunds –** Questions or concerns regarding your account or insurance claim can be directed to our billing department (214) 948-7700 Ext 201. If your account has a credit balance, we will issue a refund once all outstanding claims on your account have processed.

Assignment of Benefits:

Insurance is considered a method of reimbursing you the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage for the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service.

I understand that I am responsible for providing **FOUNDATION PAIN AND SPINE** all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

Initial_____

I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **FOUNDATION PAIN AND SPINE.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorized said assignees to release all information necessary to secure payment

Initial_____

By signing below, you agree to all terms and conditions stated above, you fully understand **FPS** financial policy and as the patient you are ultimately responsible for all liable amounts.

X_____

Patient's or Authorized Representative's Signature Todays Date