



CAROLINA SPINE & HAND, PA

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Financial Policy & Waiver

All patients must complete the “Patient Questionnaire” form before seeing the physician

INSURANCE BENEFITS

North Carolina law requires that the insurance carriers pay medical claims within 30 days. As a courtesy, we will bill your insurance for all covered services. If your insurance carrier has not appropriately paid the submitted claims within 30 days, all outstanding balances will become the patient’s responsibility.

INSURANCE CO-PAYMENTS

In accordance with my insurance contract, I understand that co-payments are due at the time of service. This contractual obligation requires that the co-payment be made at the time of service, so it may be necessary to reschedule my appointment if co-payment is not made.

DEDUCTIBLE

If my insurance deductible has not been met, I understand that full payment, up to total deductible amount, will be collected at the time of service.

CO-INSURANCE

I understand that co-insurance amounts may be collected at the time of service and when procedures are scheduled

SELF-PAY/PRIVATE PAY PATIENTS

If I have no insurance coverage, or insurance with which Carolina Spine & Hand Center, PA, does not participate, full payment is expected at time of service.

SECONDARY INSURANCE

I understand that Carolina Spine & Hand Center, PA, will file claims with secondary insurance carriers, and that I am fully responsible for secondary insurance amounts after 30 days.

VERIFICATION OF BENEFITS AND NON-COVERED SERVICES

Insurance policies may differ per patient plan. Carolina Spine & Hand Center, PA, may provide services that my insurance plan excludes. It is my responsibility to verify and understand my coverage benefits and exclusions. All non-covered services are my responsibility and are due at time of service.

HOSPITAL PROCEDURES

We will pre-certify your procedure with you insurance carrier. We will also verify your insurance benefits and get deductible and out of pocket status. From this information, we can estimate the patient portion of the physician’s fees. The patient portion of the procedure fee is due at the time admission is scheduled.

COLLECTIONS

I understand that once an account is placed in a collection status, all future services must be paid in full at time of service. If my account is placed into collections, I will be responsible for all collection costs equal to 30% of my outstanding balance, but no less than \$25.00

NO SHOW/LATE CANCELLATIONS/RETURNED CHECKS

Office visit cancellations made less than 24 hours in advance or if you are a “NO SHOW,” you will be subject to a \$25 fee. Procedure cancellations made less than 48 hours in advance or “NO SHOWS” will be subject to a \$50 fee. These charges are my responsibility and will not be billed to my insurance carrier. Returned checks will be subject to a \$25 returned check fee.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the above stated financial policy.

Patient Name _____

Signature of Patient _____ **Date** _____