COVENANT
SPINE AND NEUROLOGY

Financial Policy

By executing this agreement, you are agreeing to pay for all services that are received

Monthly Statement: You will receive a monthly statement showing previous balance, new charges, finance charges, if any, payments, and adjustments applied to your account.

Payments: The balance on your statement is due and payable when the statement is issued and is past due if not paid within 30 days of statement date. Other arrangements may be made but must be approved by us in writing. Please contact us for billing questions at 336-761-4020.

Contracted Insurance: If we are contracted with your insurance company, we must follow the terms of that contract. If you have a co-payment, you must pay at the time of service. The insurance company makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, we will assist you, BUT you are ultimately responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or denial from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final payment determination. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, we will assist you, BUT you are ultimately responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or denial from the insurance company.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these. Anyone not paying their co-payment will have their appointment rescheduled to another date.

Self-Pay: Self-pay patients must pay $250 your New Patient Visit, or $150 for Return Visits.

Returned Checks: There is a $35 fee for any checks returned by the bank. Once a check has been returned for non-sufficient funds the returned check fee and amount of the check that was returned must be paid in cash or by credit card.

Missed Appointment Fee: Patients who miss an appointment or cancel and appointment with less than 24 hours notice will be charged a $25 fee. This fee must be paid before a new appointment Is scheduled. Patients with three missed appointments will be subject to dismissal and asked to transfer records to another practice. If you have questions regarding No Show fees contact our office at 336-761-4020.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we must refer collection of the balance to a lawyer, you agree to pay the lawyers' fees which we incur plus all court cost. In case of lawsuit, you agree the venue shall be in Forsyth County, NC. Once your account goes to collections you will be discharged as a patient and asked to transfer your records to another practice. Your delinquent account may also be reported to all three credit bureaus.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we must litigate in court, or if you are past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If you claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____

Responsible Party: _____

(If not the patient)

Signature: _____ **Date:** _____

Co-Signature: _____ **Date:** _____