Coastal Pain & Spinal Diagnostics

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to delivering outstanding healthcare. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment of services is a part of that relationship. The following is a summary of our payment policy, which we require you to read and sign prior to any treatment.

We accept  **Debit, Cash and Checks**

INSURANCE CLAIMS

We will bill all medical insurance companies as a courtesy to you at no additional charge. We do collect any deductible, copayments or past due balances prior to treatment. **You are responsible for knowing your insurance benefits, deductibles and exclusion(s) of your policy.**

Failure to provide our office with accurate and complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination for your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of our usual and customary charges not covered by insurance.

SELF-PAY ACCOUNTS

If you do not have medical insurance, payment for all professional services is expected at the time of your visit. If you pay the charges in full on the day of the service, you will be eligible for our timely payment discount rate. Partial payments or payments made after the date of service will be subject to our full usual and customary rates. All quoted fees may be subject to change after 30 days. **The flat rate only covers standard office visits, injections, procedures or labs will be charged extra.**

MISSED APPOINTMENTS

Failure to cancel a scheduled appointment 24 hours in advance and not showing up for a scheduled appointment will result in a $50 **NO SHOW** fee. Please help us serve you better by keeping scheduled appointments.

PAST DUE ACCOUNTS

All patient-responsible balances that remain delinquent after 120 days, with no response from our requests for payment, may be referred to a collection agency. Once an account is turned over to the collection agency, the patient or responsible party will need to settle the debt with the agency prior to scheduling any further treatment.

I understand that I am financially responsible for all charges whether paid by insurance or not. Payment is due and payable at the time services are rendered unless prior arrangements have been made with a billing coordinator. All returned checks are subject to a $25 return check fee. Check writing privileges will be revoked and all future payments will be accepted as cash, credit card or money order.

I authorize and request my insurance company to pay all claims directly to Coastal Pain & Spinal Diagnostics and will relinquish any payments assigned to me to Coastal Pain. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have read and understand this Financial Policy and by signing below, agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Signature of Patient or Responsible Party Date

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Printed Name