PATIENT BILLING POLICY

Our goal is to provide and maintain a positive physician-patient relationship. Providing you with our financial policy in advance allows for a good flow of communication and enables us to operate efficiently. To prevent misunderstanding between patients and our practice, New York Spine Physicians (the 'Practice') adheres to the following patient financial policy. Your complete understanding of your financial responsibilities is an essential element of the physician- patient relationship and continued medical management. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

- The Practice must collect copays at the time of service and is required to report to the carrier any enrollees failing to pay the co-pay. For your convenience we accept cash, personal check, credit cards (Visa, MasterCard or Discover), and money orders. The Practice is required to collect these based on your benefit contract and the Practice's contractual agreement with your insurance carrier.

- It is your responsibility to provide the Practice with current, accurate insurance information at the time of check in and to notify the Practice of any changes in this information. A valid insurance card(s) and picture ID must be presented at the time of service

- It is the patient's responsibility to obtain insurance carrier coverage limitations.

- If the Practice does not participate with your insurance, you are expected to pay in full for our services at the time of visit. The Practice may provide assistance in filing the charges to your insurance company; however payment is expected up front.

- If you do not have medical insurance, payment for services is required at the time of the visit.

- It is the patient's responsibility to ensure that an authorization and/or referral is obtained prior to your appointment if required by your insurance.

- Patients are billed for any patient responsibility (co-insurance /deductibles/non-covered services) as determined on the Explanation of Benefits (EOB) from your carrier. Patients will receive two (2) statements for any patient balance due after insurance payment. Patients that have not made payment prior to the second statement being mailed are placed in a collection status. Patients with a delinquent balance may be sent to an outside collection service.

- Patients will receive a separate bill from third party laboratories for processing of any laboratory services. Questions about these bills should be directed to the respective lab.

- The Practice does not accept post-dated checks. Checks written to the Practice that are canceled or returned for non-sufficient funds results are assessed a $35.00 fee. To rectify your account, you will be required to pay with cash, money order, cashier's check, or credit card.

- Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

- We request that **you please give our office 24 hour notice in the event that you are unable to keep your appointment**. This courtesy allows us to be of service to other patients. **Failure to comply with this policy will result in a $25 fee for office visits and $100 fee for procedures.**

- Please be advised **that failure to request medications within four (4) business days before your medication runs out will result in a $15 fee to cover the cost of processing the refill request prior to your next scheduled appointment.**

I agree to provide information regarding health insurance, workers' compensation, automobile, and other health care benefits which the patient may be entitled. Patient assigns payment(s), if any, from insurance carriers(s)/health benefit(s) plan to New York Spine & Pain Physicians for services rendered. The direct payment assigned and authorized includes any medical insurance benefits entitled, including any Major Medical benefits otherwise payable to patient under the terms of the policy, but not to exceed the balance due for services rendered.

I understand that if my insurance company or health maintenance organization does not consider the services received as covered or has not authorized the services, then I will be fully responsible for the service provided

Our practice believes that a good provider-patient relationship is based upon effective communications. If you have any questions, please feel welcome to call 631-422-6166.

By signing below I certify that I have read and understand the Patient Billing Policy, have had the opportunity to ask questions and have them answered and accept the above conditions and terms. I further certify that I am the patient or guardian, duly authorized representative, parent or other family member of the patient.

_____ _____

Patient Name (please print) Date

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Witnessed by Practice Representative Date