SPINAL DIAGNOSTICS

Robert D. Heros, M.D. * Jason G. Anderson, D.O. * Tyler G. Huntington, PA-C * Margaret Baker, FNP

# FINANCIAL POLICY

Welcome to Spinal Diagnostics. Please take a moment to review our Payment Policies.
We require patients to provide a copy of their insurance card, proof of Identification and co-payment at check-in for every visit. If you do not have your insurance card, photo ID or co-payment with you at the time of your visit your appointment may be rescheduled.

## PATIENT RESPONSIBILITY

Patients are responsible for all charges resulting from treatment provided by Spinal Diagnostics. Payment is due in full within 30 days of receiving your first statement unless other financial arrangements have been made with the Billing Coordinator. Please remember your insurance policy is an agreement between you and your insurance company, and it is ultimately your responsibility to pay for any balance not paid or covered by your insurance company. This includes your Motor Vehicle Coverage and Worker's Compensation Coverage.

## REQUIRED PATIENT DEPOSITS-PATIENTS WITHOUT INSURANCE

We do offer a 40% discount for patients who do not have insurance. Patients will be required to pay in full at the time of their appointment. Fees will be based on provider billing and provided after the office visit.

## CO-PAYMENTS

Co-payments are the amounts your insurance policy require us to collect with each visit and are due at the time of service. Patients who arrive without their co-pay, may be rescheduled. We accept cash, check and most major credit cards. You are welcome to pay through our online payment system at onpatient.com.

## PAYMENT ARRANGEMENTS

All patients will be required to pay of their balances within 30 day of receiving their first statement unless payment arrangements have been made with Spinal Diagnostics. Please contact our Billing Coordinator at 503-885-1515 ext. 1107 as soon as possible after receiving your statement if payment arrangements are needed.

## INSURANCE BILLING

As a courtesy we will bill your primary insurance, secondary insurance, Motor Vehicle Accident, and Worker's Comp. claim for you. However, primary responsibility for the account is yours. Providing correct insurance billing information is the responsibility of the patient if your insurance changes, please present your new card at your visit. All of our providers are participating with Medicare. If you have Motor Vehicle Accident or Workers Comp claims please provide the adjusters name, contact number, claim number and the date of incident. If you do not have your insurance card with you at the time of your visit to provide us with valid insurance information, you will be billed for the services, or your appointment rescheduled.

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# FINANCIAL POLICY CONTINUED

**CANCELLATION AND RESCHEDULE FEE**

If you need to cancel or reschedule your office visit, you must notify us at least 1 business day prior to your office visit time. You may be charged a **$50** cancellation/reschedule fee from insufficient notice for your office visit. If you arrive 10 minutes or more after your scheduled appointment time, you maybe charged a cancellation fee and rescheduled.

**RETURNED CHECK OR PAYMENT FEE**

Any payments returned to Spinal Diagnostics will incur a $15 return payment charge in addition to the balance owed.

**NO SHOW FEE**

You may be charged a **$50** fee for not showing to your scheduled office visit. If you have a pattern of no shows, frequent reschedules and/or late cancellations, you may be dismissed from Spinal Diagnostics.

**PAST DUE AND COLLECTIONS ACCOUNTS**

We reserve the right to send accounts with balances that have been outstanding over 90 days from the date of service or the date of payments received from your insurance company, whichever is more, to a collection agency. If you have a balance on your account that is more than 60 days old, and over **$300**, you will be referred to the Spinal Diagnostics Billing Coordinator to make payment arrangements. If any portion of your past due amount has been assigned to a collection agency you will need to pay 100% of the balance before your appointment can be scheduled.

The patients signature (or signature of the patients parent or legal guardian) acknowledges that you understand and accept the above information. **I have read the above Financial Policy and agree with the terms of this agreement.**

Print Name_____Date_____

Signature_____

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