

Bakersfield Neuroscience & Spine Institute FINANCIAL POLICY

Thank you for choosing Bakersfield Neuroscience & Spine Institute. Our practice is committed to providing you with the highest possible care. Your clear understanding of our financial policy is important to our professional relationship. We will require that you read and sign our financial policy prior to any treatment.

INSURANCE

- If you are covered by insurance we will be happy to submit a claim for you if all necessary information is provided. Payment is subject to eligibility at time of service. Your insurance is a contract between you, your employer, and the insurance company. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.
- If you have a managed care medical insurance that we participate with, your payment of deductibles, non-covered services and co-payments are due when services are rendered.
- We accept assignment from the Medicare program. You will be responsible for your annual deductible and the 20% of the allowable charges. Secondary insurance will be billed as a courtesy if information is provided.
- If you are covered by a government sponsored program you must present your current month medical card prior to services being rendered. If your card is not available, and we are unable to verify your eligibility, services will be considered self-pay.

INDUSTRIAL PATIENTS

Your worker's compensation carrier is responsible for your medical expenses. Please provide us with complete information and make sure that authorization has been received prior to services being rendered.

CASH PATIENTS

Payment is required at time of service if you do not have health insurance. **Medical-legal consultations** are also considered cash pay and payment arrangements must be made in advance. Attorney information must be provided if applicable. Fees related to consultations will cover time associated with reports and review of records.

FEES

Fees for medical services are based on the complexity of the problem and the amount of time required for the visit. We charge what is usual and customary for our area.

Additional fees:

- \$10 service fee if copay is not paid at time of service
- \$25 service fee on any returned checks
- \$35 fee for missed appointments or failure to provide 24-hour notice of cancellation.
- Medical Records & Form Completion: Charges will not exceed the allowable for this service and are due at time of completion. Please inquire regarding fees at time of your request.

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

I have read and understand the financial policy of the practice and I 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.

Patient or Responsible Party

Date

Rev. 10/14/06

SIGNATURE ON FILE

Insurance Authorization /Assignment

I authorize the release of any medical or other information necessary to process my insurance claim. My signature authorizes payment of all medical and/or surgical benefits, to which I am entitled to **Bakersfield Neuroscience & Spine Institute**. I understand that I am responsible for charges not covered by my insurance. A photocopy of this document is considered as valid as the original.

Patient Name/ (Print)

Date

Insured's Signature

Subscriber's Number

MEDICARE

Medicare Authorization/Assignment

I request that payment of authorized Medicare benefits are made on my behalf to **Bakersfield Neuroscience & Spine Institute**, for any services furnished me by Bakersfield Neuroscience & Spine Institute. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agencies any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim for or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Patient Name (Print)

Date

Insured's Signature

Patient's Medicare Number

Medigap Assignment of Benefits

I request the payment of authorized Medigap benefits be made either to me or on my behalf to **Bakersfield Neuroscience & Spine Institute** for any services furnished me by Bakersfield Neuroscience & Spine Institute. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits payable for related services.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient Name (Print)

Date

Patient's Signature

MediGap Number