SPINE & SCOLIOSIS SPECIALISTS

2105 Braxton Lane, Suite 101 • Greensboro, NC 27408
4590 Premier Drive • High Point, NC 27265
Phone: (336) 333-6306 • Fax: (336) 333-6309

FINANCIAL POLICY

Welcome to our practice. Thank you for choosing us as your health care provider. We want you to be informed of our financial policies so that you will know what to expect as treatment progresses. If you have any questions or concerns about the financial aspects of your care, our Patient Financial Counselor is available to assist you.

You must bring your insurance card to every visit to ensure that we have current and accurate information. If we are unable to verify your coverage, you will be considered self-pay. We participate with many insurance carriers, including Medicare. Your insurance coverage is a contract between you and your insurance carrier. Please check with your insurance carrier to determine if we are in-network or out of network, and how that will affect your financial responsibility. Some insurance carriers require you to obtain authorization from your primary care physician to be seen by a specialist. Obtaining this authorization, and staying within its parameters, is your responsibility. Check with your carrier about the specific requirements of your policy, as failure to follow their requirements will result in your being responsible for the bill. As a courtesy to you, we will file your insurance claim. If your insurance carrier rejects the claim, or denies payment, you will be responsible for the bill.

All patient-responsibility amounts are due at check-in, including co-pays and unmet deductibles. If you have no insurance, be prepared to pay a minimum of $260 as a deposit toward your initial visit, plus the cost of x-rays as needed. The actual charge may vary, and you will be charged the lesser of the two amounts. Any subsequent visits must also be paid at the time of service. We may offer a discount to our uninsured patients if the entire balance is paid at the time of service. If you are not prepared to pay your patient responsibility amount, we reserve the right to reschedule your appointment.

Our staff will work with you to determine your anticipated financial responsibility for your surgery or procedure as needed. The estimated amount is due a minimum of three days before the service is rendered.

Failure to pay your balance may result in your account being placed with a collection agency. If that happens, you are responsible for the outstanding balance as well as any finance charges, attorney fees, and/or collection agency fees. Checks returned to us by your bank as non-payable will incur a $25.00 handling fee. This fee, in addition to the amount of the check which was returned, must be paid before your next visit.

We accept Visa, MasterCard, HSA debit cards, and Care Credit for your convenience. We also accept personal checks (no starter or post-dated checks), and cash.

Acknowledgment: By signing below, you agree to the terms listed above. You also authorize Spine & Scoliosis Specialists to release information to your insurance carrier or attorney as needed to ensure payment of the claim. If your account becomes delinquent, you agree to pay all costs incurred in collecting the account.

Signature:_____ Date:_____

Printed Name:_____ Relationship to Patient:_____