SOUTHERN ORTHOPEDIC SPINE SURGERY DR. GAISER

FINANCIAL PAYMENT POLICY

1. REGARDING INSURANCE: The services provided in our office are provided directly to you and you are responsible for payment of services rendered. Our office participates with Medicare and many other insurance companies. Should your insurance coverage be with one or more of these companies we will, as a courtesy to you, bill your insurance along the guidelines of our contract with that company. However co-payment, deductibles, and non-covered charges are the responsibility of the patient and payment is expected at the time services are rendered. Those who only have a co-payment for services will need to pay that co-payment at time of check-in each visit.

2. SELF PAY/NO INSURANCE/BALANCES AFTER INSURANCE-
The services provided in our office are provided directly to you and you are responsible for payment of services rendered at time of check out. If you are unable to pay for the services in full at time of check out then you will need to pay at least $100.00 and then set up a weekly/monthly payment plan with our office. You have to option to put a credit card number on file so your payment can be automatically charged each month. We offer payment plans for monthly, 3 months and 6 months.

3. COLLECTION FEES: You will receive 3 bills mailed to your home address on file. After 3 bills have been sent and there is still a balance on your account, the account will be turned over to our collections department.

Informing our patients of our financial policy assists us in providing the best services to our patients. Thank you for taking the time to read this policy statement. Should you have any further questions or comments, please feel free to contact our office.

I hereby understand the financial policy of this office:

_____ _____

Patient Name (PLEASE PRINT) Patient or Legal Guardian Signature

_____

Date

INSURANCE AUTHORIZATION

Please sign if we are filing ANY insurance company on your behalf

I request that payment of authorized insurance benefits be made on my behalf to the provider for any services furnished to me by the listed provider. I authorize any holder of medical information about to release to the Health Care Financing Administration and its agents any information needed to determine these 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(s). If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms of electronically submitted claims, my signature authorized release of the 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 only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the insurance companies.

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Patient or Legal Guardian's Name (PLEASE PRINT) Patient or Legal Guardian's Signature