

SPINE SURGERY ASSOCIATES, P.C. - Financial and Insurance Policies

By signing this sheet, you agree that the above information given to Please be advised that you as the guarantor (patient, the parent or guardian, or the insured) are responsible for payment of all fees regardless of insurance coverage. I f you are insured through a government sponsored plan or a managed care organization, we may be contracted with that plan and we may have agreed not to bill you for any balances other than the deductibles and co-pays. If your insurance coverage denies payment for services rendered, you then become the responsible party. If your valid insurance does not reimburse Spine Surgery Associates, P.C. within 90 days of our sending a claim, the amount due will be reclassified as the guarantor's responsibility. Additionally, if the account remains unpaid after 150 days from the date of service, we may assign your account for further processing and you will be responsible for any associated fees.

Date of First Symptoms/Date of Injury \_\_\_\_\_ Related to Job? \_\_\_\_\_ Vehicle Acc? \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Insured's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_ Patient ID# \_\_\_\_\_ School Ins Y N Employer Ins Y N

\*\*If Insurance is through employer, name of Employer \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Insured's Name \_\_\_\_\_ DOB \_\_ / \_\_ / \_\_

Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_ Patient ID# \_\_\_\_\_ School Ins Y N Employer Ins Y N

\*\*If Insurance is through employer, name of Employer \_\_\_\_\_

In order for us to file an insurance claim on your behalf and the insurer to process the claim, your consent to release medical information is required.

I authorize the release of medical information necessary to process my insurance claim. Furthermore, I authorize payment of medical benefits to Spine Surgery Associates, P.C. for services rendered by Dr. Paul Broadstone, Dr. Richard Pearce, Dr. Todd Bonvallet, Dr. James Osborn, Dr. David Lowry, and any Spine Surgery Associates staff.

\*Authorized signature \_\_\_\_\_ Date \_\_\_\_\_  
\*Pleased be advised that insurance will not be filed without your signature to release information to the insurance company.

By signing this sheet, you agree that the above information given to Spine Surgery Associates, P.C. is accurate and complete. Furthermore, you agree that you are responsible for payment of fees, deductibles, and/or co-pays, unless specifically exempt by contract and that you understand our financial policies as described above.

\*\*Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_  
\*\*Failure to sign and accept financial responsibility for services rendered may result in cancellation of your appointment/denial of services.

I have the right to expect that my protected health information will remain private. I have had the opportunity to obtain the Spine Surgery Associates Notice of Privacy Practices (as required by law).

Authorized signature \_\_\_\_\_ Date \_\_\_\_\_