ANN ARBOR SPINE CENTER

Patient Financial Policy

Thank you for choosing Ann Arbor Spine Center for your spine & neuroscience needs. Our doctors and staff are committed to providing quality, affordable medical care without regard to financial status.

We participate with the following insurance companies: Blue Care Network, BCN Advantage, Blue Cross Blue Shield, HAP (HMO only), HAP Senior Plus, Health Plus PPO, Medicare Plus Blue, Medicare, Medicaid, (including Midwest Health Plan & Washtenaw Health Plan) Priority Health, Cofinity, Aetna, Workman's Compensation and Auto.

Self-Pay Accounts

We designate accounts, **self-pay**, under the following circumstances: (1) patient is covered by an insurance plan that our providers do not participate in (2) patient does not have a current, valid insurance card on file, (3) patient does not have a valid insurance referral on file, or (4) patient does not have health insurance coverage. As a courtesy, we will bill the insurance company for you if we are out of network, but you are ultimately responsible for charges incurred. We accept cash, checks, Visa, Mastercard and Discover. A $35.00 return check will be charged for any NSF checks.

Proof of Insurance

Please bring your insurance card(s) with you to each appointment. It is your responsibility to notify the practice of changes in your health insurance.

It is your responsibility to inform the receptionist when the cause of treatment may be the responsibility of a third party (auto insurance, liability insurance company, worker's compensation) instead of your regular health insurance carrier. **You are responsible to provide the office with all information required to bill the third party insurance at your appointment.**

Referrals

If your insurance plan requires an authorization to be seen, you are required to get the authorization from your primary care doctor before your appointment. If you are unsure if your insurance requires an authorization, please contact your insurance company. If you do not have a current, valid authorization, we may ask you to either reschedule your appointment or pay for the visit at time of service.

Our Responsibility to Report Non-Compliance

It is our obligation under many insurance contracts to report patients who repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for appointments. Please be aware that our office charges a $50.00 fee if you fail to cancel your scheduled appointment 24 hours prior to the scheduled time.

Forms Completion

If you need a specific form to be completed by our office (i.e. mortgage, creditcard, auto loans, etc.) there is a $25.00 fee due prior to completion of form.

Billing, Payments and Refunds

All balances are due in full within 30 days of the statement date.

If you cannot pay the balance in full within 30 days, please contact our billing company, MBR, at 248-932-2607 to see if you qualify for special payment options.

It is your responsibility to notify the office of any changes in address, phone number, employment or insurance coverage.

If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.

We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice.

It is the policy of this practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect or discount copays, coinsurance, deductibles or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.

All charges are your responsibility whether your insurance company pays or not.

Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance carrier. We do not get involved with disputed claims or litigation.

By signing below, I acknowledge that I have read and understand the Financial Policy of the Ann Arbor Spine Center & Neurosciences and agree to the payment terms and my obligation under the Financial Policy.

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Patient Name (please print) **Date of birth**

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Signature of Patient or Legal Guardian **Date**