

PATIENT PAYMENT POLICY



Thank you for choosing the New York Spine and Wellness Center. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services.

We will do our best to be knowledgeable about all of the many different insurance plans, however, it is the patient's responsibility to know their insurance and what may or may not be covered. Please sign below that you have read and agree to this Policy.

- All co-pays to are to be paid at check-in, the day of your visit. **We do not waive co-pays.** We accept cash, check, Visa, MasterCard, Discover and American Express.
- All fees are based on the type of service provided for your care & related services. The fees are competitive for this region.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined in this document.
- In the event you have a past due balance, we will work with you to remedy the situation; you may experience an interruption in your care until the matter is settled.
- If your account is more than 180 days overdue, it will be referred to a collection agency. This is a last resort and done reluctantly after we have exhausted efforts for voluntary payment. You will be responsible for all reasonable collection costs incurred by our practice.
- If you have, or will be receiving a workers comp settlement, or a "Section 32", related to the same injuries we treat you for, you will be held solely responsible for the bills, **not your private insurance company.** You will be expected to pay the day of your visit.
- **We do not participate with No-Fault.** As a courtesy, we will bill your NF carrier if you agree to sign the Authorization to Pay Form. In the event your carrier payment is delayed or denied for any reason, **YOU will be held solely responsible for all bills.**
- **Claims denied by your NF carrier due to your non-compliance with your NF carrier, will not be billed to your private insurance. This includes, but is not limited to Medicaid or a Managed Medicaid Product.** You immediately become responsible for all outstanding charges.
- If a service provided to you, is denied by your insurance carrier for any of the following reasons, but not limited to: non-covered service, experimental, investigational or not medically necessary, you will be responsible for the payment of the service. **Please verify coverage of services with your insurance carrier.**
- An estimated cost for the service is available upon request.
- Do not make any notations or changes to this document, if you do, we will not be able to treat you.

Acknowledgement and Authorization

I have read, understand, and agree to all of the above. I understand that charges not covered by my insurance company, **as well as co-payments and deductibles, are my responsibility.**

I authorize my insurance benefits to be paid directly to New York Spine and Wellness Center. I authorize New York Spine and Wellness Center to release any medical or other information to my insurance company when requested.

Signature of Patient/Relative/Guardian*

Patient DOB

Print Name of Patient

Relationship to Patient

Print name of Relative/Guardian*

Interpreter (if required)

Today's Date

* The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.