

Payment for services provided by **Michigan Head & Spine Institute, PC**, are your responsibility. As a courtesy to our patients, we will bill most insurance plans for services provided. However, in order to receive payment from the insurance company, both you and **Michigan Head & Spine Institute, PC**, are required to follow the rules of that company. **Please let us know of any change in your insurance.**

ASSIGNMENT OF BENEFITS

I authorize any payments be made to **Michigan Head & Spine Institute, PC** by my insurance company or carrier or other payor related to medical services provided.

RESPONSIBILITY OF PAYMENT FOR MEDICAL SERVICES

I agree to pay in full any and all charges for medical services provided to me by **Michigan Head & Spine Institute, PC** not otherwise covered by my Medicare, insurance company or carrier, or other payor.

E-MAIL COMMUNICATIONS

- Some of our patients wish to communicate with physicians and staff via e-mail. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations effective April 14, 2003 require that you have the right to have your Health Information protected. E-mail information can be intercepted and viewed by others that are not known to you or your physician.
- I am aware that it is possible that some of my Health Information may not be protected through e-mail communication.

Yes, you may communicate with me via e-mail **No**, do not use e-mail to communicate with me

PAYMENT POLICY

- We understand that it is not always possible to pay in full at the time of service. If you are unable to pay in full at the time of service and you have made prior arrangements with us, we will bill you for the services rendered and payment in full will be required within thirty (30) days of the invoice date. If your account remains unpaid past that 30-day period, the balance will be subject to a service payment fee equal to \$5 per month. Your account will be considered in default 150 days after it is determined to be a patient's responsibility and if payment arrangements are not made and completed as agreed.
- We use the services of MedDirect to service our accounts prior to default to help you make arrangements to pay your bill. A processing set-up fee may apply. I hereby authorize any holder of financial and insurance information about me to release said financial and insurance records to MedDirect or any other person providing account services.
- All co-payments / deductibles must be paid at front desk on your scheduled visit. Failure to make payment will result in a \$10 statement fee billed to your account at the end of each month. Elective procedures will not be scheduled prior to payment or payment arrangements.
- We will make every attempt possible to collect payment from your insurance for services rendered. Any balance over 45 days old will be transferred to patient responsibility in an effort to settle the balance. You can assist by contacting your insurance company.
- You will receive a total of three statements in effort to collect patient balances. After non-payment or lack of payment arrangements the balance will be sent to collections. There will be a 30% fee charge based on your balance to all accounts sent to collections. This represents what all collection agencies charge.
- Payment requirements for accounts in collections will consist of 50% of outstanding balance to be paid before scheduled visit.
- For patients seeing a Physical Medicine & Rehab physician, there is a \$50 charge for all no-shows without a twenty-four hour cancellation notice.
- There will be a \$30 charge for all returned checks.
- There is a charge of \$25 for completion of every form with the exception of the following:
- Off work or return to work letter for your employer
- Forms for patients on medical assistance (Medicaid or Adult Benefit Waiver Program)
- Charge for a case manager to meet with the physician at the time of the patient's office visit is \$25.00, payable prior to office visit. *(This only applies if you have a Case Manager for Worker's Compensation, Auto or with some medical insurances.)*
- This assignment can not be voided or withdrawn until account is paid in full.

Patient Name _____ Date of Birth _____ SS# _____
(Please Print)

Patient or Parent/Guardian Signature _____ Date _____ Account # _____
(If guardian, copy of guardianship papers to be attached)