ADVANCED SPINE & REHAB PC
Patient Financial Responsibility Agreement

Please initial all appropriate lines, sign, and date the bottom.

Patient Name _____

We gladly accept cash and all major credit cards as forms of payment. Personal Checks are NOT accepted. Co-Payment, deductibles, co-insurance and any other charges are due at the time of check in. Insurance claims will be submitted on your behalf up to the point of a 1st level appeal. After that any balances will become patient responsibility unless and until the claim is paid to us. I understand that I am financially responsible for any and all charges not covered by my insurance for ANY reason. Including but not limited to; non-covered services, diagnosis not covered, service prior to or after coverage is effective, service not covered under provider contract, PCP other than our office or no PCP selected, pre-existing conditions, failure to return necessary paperwork to your insurance in order to ensure processing of claim, or failure to provide us with correct insurance billing information. _____

I further understand that insurance is NOT a guarantee of payment, and benefits are subject to terms of your individual policy. Please make yourself familiar with your benefits and policy provisions. It is your responsibility to know your benefits. _____

I understand there is a charge ($25.00-$75.00 as determined by the office) for all forms or letters written or completed by a provider in this office, (disability, FMLA, insurance assessments etc.) This fee is separate from co pays etc. and must be paid before the form or letter will be completed.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if still unpaid after 60 days from the first billing date.
In the event that an account is turned over to a third party for collection I will pay all reasonable collection, court or attorney costs. Care will NOT be provided while your account is in collection. Accounts that become delinquent more than once will be considered for termination of care with this practice. _____

Medical records requests require a minimum of 7 days. If being released to you there is a $30 fee for the first 100 pages and .25 cents per page thereafter. A photocopy of this agreement shall be considered valid and treated as original. _____

PATIENT'S PRINTED NAME _____

DATE _____

PARENT *or* LEGAL GUARDIAN'S PRINTED NAME _____

PATIENT'S SIGNATURE (*if a minor, Parents or Legal Guardian Signature*) _____

Advanced Spine and Rehab PC
Advanced Family Healthcare PLLC

PATIENT CONSENT AUTHORIZATION

I, _____, do hereby authorize Advanced Spine and Rehab / Advanced Family Health care to release any medical information to the following person (s) listed below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I do understand I am responsible for filling out a new form if any of this information needs to be changed. If there are any charges, you are responsible for paying before the records are picked up.

☐ Please check the box if you do NOT want any person EXCEPT YOU to receive medical information.

Medicare Authorization:
I request that payment of authorized Medicare benefits be made on my behalf to Advanced Spine & Rehab PC for services furnished to me by this clinic. I authorize any holder of medical information about me released to Medicare and its agent, any information needed to determine these benefits payable for related services. I permit a copy of this to be used in place of the original.

Assignment of Benefit:
I hereby authorize payment of medical benefits to Advanced Spine & Rehab PC for services rendered to myself and/or dependents. The signature below shall suffice for all insurance forms on a continuing basis.

Primary Care Physician Designation:
I understand that I am responsible for complying with the rules and regulations of my insurance company regarding the requirements for designating a provider from Advanced Spine & Rehab PC as my primary care physician and that failure to do so may result in a higher out of pocket expense to me.

Notice of Privacy Practices:
I acknowledge that I have been given the opportunity to review and/or received a copy of the information contained in the HIPAA Privacy Act Pamphlet.
Please sign as acknowledgement that you have been notified of the above policies.

Consent for treatment:
I voluntarily consent to the rendering of care, including treatment and performance of procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

I have read and fully understand this agreement.

PATIENT'S NAME _____ DATE _____

PATIENT'S SIGNATURE (*if a minor, Parents or Legal Guardian Signature*) _____

NO SHOW / CANCELLATION POLICY

NO SHOW POLICY:

NO SHOW: A 'No Show' is someone who misses an appointment without cancelling it in an adequate manner.

A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a 'No Show'.

● **First missed appointment**: there will be no charge

● **Second missed appointment**: there will be a 'No Show' charge added to the patient account

This charge will vary from $25-$50, depending on the type and length of the appointment that was missed. The charge will be added to the patients account and must be paid on or before your next scheduled appointment.

● **Third missed appointment**: there will be a 'No Show' charge… and…

After the 3rd 'No-Show' appointment (if the 'No Show' charges have not been paid), the patient is no longer permitted to schedule any future appointments.

CANCELLATION POLICY:

In order to be respectful of the medical needs of other patients, please inform the office promptly if you are unable to attend a scheduled appointment. This is how we can best serve the needs of our patients.

If you have been issued a sooner appointment and no longer need your subsequent scheduled appointment, please make sure to confirm with the front desk staff that the appointment is cancelled so this time can be made available to other patients in need of medical care.

● If it is necessary to cancel your scheduled appointment, we request at least a 24 hour notice.

● Late cancellations can potentially be considered as a 'No Show', resulting in a late charge.

We understand urgent matters may arise and appreciate your effort and cooperation.

I have read and understand the appointment cancellation / No Show Policy and agree to its terms.

PATIENT'S PRINTED NAME _____

DATE _____

PARENT *or* LEGAL GUARDIAN'S PRINTED NAME _____

PATIENT'S SIGNATURE (*if a minor, Parents or Legal Guardian Signature*) _____