Payment Policy

This is for your review only. An electronic signature will be requested at your scheduled appointment.

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Please read the following payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate with most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Returned Check Policy.** We accept cash or personal checks as the only forms of payment. All returned checks will incur a minimum of $25.00 in Returned Check Charges. You will receive a letter with a copy of the returned check notice. The letter will clearly state the additional $25.00 fee will be added to the original amount owed. This letter will advise you that you will now be placed on a Bounced Check Checklist and that you will now have to pay cash for any amount owed.

5. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

10. **Surgery.** If your physician recommends surgery, you will be escorted to the Surgical Coordinator. The Surgical Coordinator will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. The Surgical Coordinator may request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. It is your responsibility to know your surgical benefits for the professional and for the facility prior to your surgery.

11. **Billing Contact Policy.** Per the Federal Communications Commission's ruling, as a medical provider's office we are required to retain written permission to contact our patient's via cellular telephone regarding billing questions or management. By signing below, you are in agreement of Neurosurgery of Western NY's allowance to contact you via any phone number you have provided regarding insurance matters or for billing account balances and inquiries. You are also in agreement that it is permissible to leave voice messages regarding any information that requires your attention. Refusal to sign this agreement is reason for us to decline your acceptance as a patient.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Neurosurgery of Western NY.

I authorize Neurosurgery of Western NY to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.