SPINE INSTITUTE
OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

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Patient Financial Policy Agreement

Thank you for choosing the Spine Institute of Central Florida as your health care provider. We are committed to providing you with the best possible care. Payment of your bill is considered a part of our professional relationship and a clear understanding of our financial policy is important.

Insurance is a means of payment but does not relieve you from financial responsibility. Typically, insurance carriers have designated patient contributions in the form of co-pays, deductibles, and co-insurance amounts. These amounts vary widely between insurance providers and amongst the large variety of contracts within an insurance company. Because your insurance contract is between you, your insurance company and/or your employer, we encourage you to take an active role in understanding your benefits and out of pocket expense. As the insurance subscriber, you have the ability to obtain the most accurate and detailed information regarding your insurance plan. As a third party, Spine Institute of Central Florida does not have access to the same information that is provided to the insurance subscriber. Therefore, it is your responsibility to identify what services are covered, what services are not covered, what facilities are covered, and what your financial responsibility will be if you proceed to receive any service on any given day. Ultimately, payment of the charges for services rendered to you is your responsibility.

We participate with most major payers, which mean that covered charges will be paid directly to us based upon your benefit plan. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you directly and will be due no later than 30 days from the date of the billing statement. You are responsible for payment until the account is paid in full.

If there is a remaining balance after we receive payment from your insurance carrier, you will be billed for that amount. Additionally, if payment from your insurance carrier is delayed beyond a reasonable amount of time (in no event greater than 90 days from the date of service), then you will be expected to immediately make payment, after which you can thencontact your insurance carrier for possible reimbursement.

If your insurance carrier fails to pay your claim, they should explain to you why it was rejected. If you are dissatisfied with their rejection, or the amount they pay, it is your responsibility to take the matter up directly with your insurance carrier. Out of courtesy, we will be happy to file an appeal on your behalf, but please do not blame Spine Institute of Central Florida, and do not seriously jeopardize your credit rating by not paying your bill promptly. You are responsible for cooperating with requests for additional information and assistance with appeals.

It is your responsibility to provide all information necessary to facilitate “Coordination of Benefits (COB)” with your insurance payer(s) as quickly as possible; including appropriately updating your COB information with your insurance company and promptly completing and returning any COB related forms sent to you from your insurance company. Failure to provide this information to your insurance payer(s) in a timely manner will result in claim denials and non-payment from your insurance payer(s). If your insurance payer denies payment of any claims for failure to provide and/ordelay in providing information necessary to facilitate “Coordination of Benefits;” you will be responsible for payment of allcharges associated with the care provided to you.

If you do not provide your complete insurance information (including: a copy of my insurance card, member ID number(s),group number(s), name of the beneficiary, and date of birth of the beneficiary) to our facility to allow submission of charges for your medical care to your insurance payer or do not authorize us to file claims to your health insurance; you will be responsible for payment of all charges associated with the care provided to you.

Every insurance payer has a timely filing requirement. Therefore, if you provide your correct and complete insurance information to our facility after service has already been rendered, or if you do not authorize us to make submissions; youwill be responsible for payment of charges for services rendered. When care is being provided for personal injuries sustained where there is third-party liability insurance, if your PIP/MedPay benefits become exhausted; charges for your care will be submitted to your predetermined, preferred payment source. Customarily, most insurances require medical claims to be submitted to your PIP/MedPay prior to being submitted to your health insurance carrier. Therefore, when written noticeof PIP/MedPay benefit exhaustion is received by SICF; the services rendered to you will then be submitted to your predetermined, preferred payment source. If, at that time, the timely filing requirement for your predetermined, preferred payment source has passed; you are still ultimately responsible for payment of all charges for services rendered to you. However, we will still submit the claims on your behalf to provide your insurance payer with a record of

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your care.

Additionally, if your insurance payer requires prior authorization and the service has already been rendered to you; your insurance payer may deny the claim for lack of prior authorization. By initialing below, I agree to this process of claim submission and do understand that this may result in waiving my rights as a third-party beneficiary under the contract between SICF and my health insurance company; if, for example, the timely filing requirement is not met due to the process described above.

If your insurance denies payment of any claims for the reasons stated above; you will be responsible for payment of allcharges associated with the care provided to you.

It is your responsibility to determine whether our facility is in-network or out-of-network with your insurance carrier. If we do not participate in your insurance plan, you may still choose to be seen by the practice and your claim may be eligible for “out-of-network” benefits, which typically result in additional out of pocket expense. It is your responsibility to determine what out-of-networks benefits, if any, are available to you. You will be responsible for payment of all charges that are not covered by your insurance; and all charges related to your out-of-network status. Again, to emphasize, you are responsiblefor knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services at Spine Institute of Central Florida, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your insurance company provides incorrect or misleading information to SpineInstitute of Central Florida during prior authorization, when such information is relied upon, but actually different from yourplan benefits; (iv) your health plan determines that the services you received at Spine Institute of Central Florida are not medically necessary and/or not covered by your insurance plan; (v) your health plan coverage has lapsed or expired at the time you receive services at Spine Institute of Central Florida; or (vi) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your insurance company directly.

We require you to present proof of insurance at each medical visit. If we are unable to verify your insurance or you do not have your insurance card, you will be considered a self-pay patient and payment will be due at time of service. Insurancestatus presented at time of service will be considered the final status for that visit and retroactive changes are not processed.

Consistent with insurance regulations, co-pays, deductibles, and co-insurance amounts are due at the time of service. We accept cash, Visa, MasterCard, American Express, and Discover for your convenience. Additional fees, which are typically not covered by your insurance plan, will be charged for services such as copying medical records, completion of disability forms, and other such services.

Interest and Attorney’s Fees, and No-Show Fees: On all accounts with balances greater than 30 days past due an 18% per annum interest will be charged. There will be a $50.00 charge for any no-show to office visit, physical therapy, and MRI appointments. There will be a $300.00 charge for any no-show to a scheduled in-office procedure. If you cancel your appointment less than 24 hours prior to your appointment, a fee of $25.00 will be applied to your account. As much as we hope to avoid collection activity, we must inform you that delinquent accounts may be assigned to collections agency and all collection costs will be added to your outstanding balances. You shall be responsible for all costs and expenses incurred in efforts to collect past due amounts from you, including interest charges, court costs, and reasonable attorney's fees. If my account is sent to a Collections Agency, I understand and agree that a 30% collection fee will be applied to the sum of my outstanding balance and applicable interest charges. In other words, your amount due will be increased by 30% of the total amount of your outstanding balance and applicable interest charges. Additionally, patients with delinquent accountsmay be dismissed from our practice.

Overpayments: If you make a payment that results in a surplus on your account, you authorize Spine Institute of Central Florida to apply the overpayment to any other account for which you are financially responsible; includingyour account, a member of your family’s or dependent’s account, or on any account for which you are a financially responsible party, which has an outstanding balance. Any remaining balance will be promptly returnedto you, but only if there are no further outstanding balances, unresolved and/or pending insurance payments for services provided.

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Ancillary Services: You may receive ancillary medical services while a patient of Spine Institute of Central Florida such as: anesthesia, interpretation of tests, neuropsychological testing, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. By signing below, you understand that some physicians may not provide services in your presence but are actively involved in the course of diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges as a result of these ancillary services. You agree to pay all charges duewith respect to such services after benefits paid on your behalf by any third-party are credited to your account.

If your insurance company sends you a questionnaire, please complete and return it promptly or you will be asked to pay the bill directly.

All care and services provided by Spine Institute of Central Florida are being performed in good faith that you and/or your insurance will fully pay for services rendered, and in reliance of the financial policy agreement. For all services rendered by Spine Institute of Central Florida, you guarantee payment of your account at the time services are provided for any and all balances that are not paid by an insurance carrier, government payer, or other third-party payer (together, referred to as “PAYER”), including if your PAYER denies a claim after first approving it. You understand that any out-of-network charges may be your responsibility as determined by your PAYER. You acknowledge that you will be responsible for paying Spine Institute of Central Florida for items and services provided to your dependents under these same policies, terms, and conditions whether or not you are listed as the “Responsible Party” on the Patient Account. The person listed as the “Responsible Party” on the Patient Account will also be responsible to Spine Institute of Central Florida for payment. All charges incurred are your responsibility.

Patient Financial Agreement:

I certify that the information that I have reported with regards to my insurance coverage is correct. I further authorize the release of any information necessary to my insurance company to determine benefits for services rendered. I request thatpayment of authorized benefits be made payable directly to the Spine Institute of Central Florida on my behalf.

I understand and agree that it is my responsibility to determine from my insurance company whether prior authorization or referral is required for any service I receive, including my initial evaluation and procedures, and to ensure such authorization is obtained prior to my appointments. Otherwise, I understand it will be my responsibility to pay all charges for services rendered to me.

After any service is rendered, I understand I am ultimately responsible for payment of the care provided. If my insurance company delays in making payment for any reason, I am responsible for payment of all charges associated with the careprovided. I understand such payment will be due immediately and must be paid within 30 days from the date of the billingstatement. After I have made payment of the full balance on my account, I may choose to seek reimbursement from my insurance carrier as needed. Ultimately, it will be between me and my insurance company as to whether or not I receive any reimbursement for payments made to Spine Institute of Central Florida.

I understand that if I do not agree with this Financial Agreement, full payment for each service received is required prior toeach service. I acknowledge that when any service(s) is rendered at SICF without me first FULLY pre-paying for charges relating to such service(s), such service is only performed in reliance of this agreement. By signing this Agreement, I am voluntarily agreeing to all its terms and stipulations. I understand and agree that, regardless of my insurance status or anyinsurance company decisions, I am responsible for payment of the balance on my account for any service rendered. I have read the above Financial Policy and agree to be bound by it. I have provided the Practice with the true, correct, and complete insurance information. Finally, I will notify the Practice promptly of any changes in my health care insurance coverage.

Signature of Patient/Responsible Party Signature of Witness Date