Coastal Spine & Pain

INTERVENTIONAL PAIN MANAGEMENT

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FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

Please read this document carefully. By signing below, you agree to the terms outlined herein.

FINANCIAL RESPONSIBILITY

Thank you for choosing Coastal Spine & Pain, LLC for your healthcare needs. We are committed to providing you with the highest quality pain management care. The following is a statement of our financial policy, which we require you to read and sign prior to receiving treatment. Our goal is to be transparent about our billing practices and to help you understand your financial obligations.

INSURANCE & VERIFICATION

1. Insurance Filing. As a courtesy, we will file claims with your insurance carrier on your behalf. However, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You are ultimately responsible for payment of all charges incurred at this office, regardless of insurance coverage or the outcome of any insurance claim.

2. Verification of Benefits. We will verify your insurance eligibility and benefits prior to your visit whenever possible. Please be aware that verification of benefits is not a guarantee of payment. Your insurance company makes the final determination regarding coverage and payment at the time the claim is processed.

3. Insurance Information. You are responsible for providing us with accurate and current insurance information at each visit. If your insurance information changes at any time, you must notify us before your next appointment. Failure to provide current insurance information may result in claims being denied, in which case you will be responsible for the full balance.

4. Referrals and Authorizations. If your insurance plan requires a referral or prior authorization for services, it is your responsibility to obtain such authorization before your appointment. If you arrive without the required referral or authorization, we may need to reschedule your appointment or you may be asked to pay for services in full at the time of service.

PAYMENT POLICIES

5. Copayments, Deductibles, and Coinsurance. All copayments, deductibles, and coinsurance amounts are due at the time of service. This is a requirement of your insurance contract and is not optional. We accept cash, personal checks, major credit/debit cards (Visa, MasterCard, American Express, Discover), and health savings account (HSA) or flexible spending account (FSA) cards.

6. Self-Pay and Uninsured Patients. Patients without insurance coverage or who choose not to use insurance benefits are considered self-pay. Payment in full is expected at the time of service. Self-pay patients are entitled to a Good Faith Estimate of charges in advance of scheduled services, in compliance with the No Surprises Act (effective January 1, 2022). If you would like a Good Faith Estimate, please contact our billing department.

7. Outstanding Balances. After your insurance company has processed your claim, you will receive a statement for any remaining patient balance. Payment is due within thirty (30) days of the statement date. If payment arrangements are needed, please contact our billing department promptly. Accounts that remain unpaid beyond ninety (90) days may be referred to a third-party collection agency, and you will be responsible for any additional collection costs incurred.

8. Returned Checks. A fee of $30.00 will be charged for any check returned by your bank for insufficient funds. Subsequent payments may be required by cash, cashier's check, or credit/debit card.

APPOINTMENT & CANCELLATION POLICY

9. Missed Appointments / No-Shows. We understand that circumstances arise that may require you to cancel or reschedule an appointment. However, when a patient misses an appointment without proper notice, it prevents another patient from receiving care. We require a minimum of 24 hours' advance notice for cancellations or rescheduling. Patients who fail to provide 24 hours' notice or who do not show for a scheduled appointment may be assessed a missed appointment fee of up to $50.00. This fee is not billable to insurance and is the patient's responsibility. Repeated no-shows may result in dismissal from the practice.

10. Late Arrivals. If you arrive more than 15 minutes past your scheduled appointment time, you may be asked to reschedule to ensure that all patients receive adequate time with the provider.

PROCEDURES & SURGERY CENTER BILLING

11. Separate Billing for Procedures. If your treatment plan includes a procedure performed at an ambulatory surgery center (ASC) or other facility, please be aware that you may receive separate bills from the facility, the physician, the anesthesiologist (if applicable), and any other providers involved in your care. Our office bill covers the physician's professional fee only. Any facility, anesthesia, or ancillary charges are billed separately by those entities.

12. Pre-Procedure Financial Obligations. Prior to any scheduled procedure, our office will verify your insurance benefits and provide you with an estimate of your anticipated out-of-pocket costs. Any patient responsibility (copay, deductible, coinsurance) must be paid prior to or on the day of the procedure. Failure to satisfy pre-procedure financial obligations may result in the procedure being rescheduled.

AFTER-HOURS TELEPHONE CALLS

13. After-Hours Telephone Calls. Our after-hours answering service is reserved for urgent medical issues. After-hours calls that are determined not to be an emergency — including requests for pain medication or requests to change pain medication — may be assessed a $25.00 administrative fee. This fee is not billable to insurance and is the patient's responsibility. Please see our Phone Call Policy for additional details.

ASSIGNMENT OF BENEFITS

By signing below, I authorize and direct my insurance company(ies) to make payment of all insurance benefits directly to Coastal Spine & Pain, LLC for services rendered. I understand that this assignment of benefits does not relieve me of my financial responsibility for charges not covered by insurance, including but not limited to copayments, deductibles, coinsurance, and non-covered services.

I further authorize Coastal Spine & Pain, LLC to release any medical information necessary to process my insurance claims, appeal denied claims, or as otherwise required for billing and collection purposes. This authorization shall remain in effect until revoked by me in writing.

ACKNOWLEDGMENT & AGREEMENT

By signing below, I acknowledge that I have read and understand this **Financial Policy & Assignment of Benefits**. I agree to abide by the terms set forth herein. I understand that I am financially responsible for all charges incurred at Coastal Spine & Pain, LLC, regardless of insurance coverage. I understand that this agreement will remain in effect unless I revoke it in writing.

Patient Name (Printed) _____ Date _____

Patient Signature (or Legal Representative) _____ Relationship to Patient (if applicable) _____