Payment and Billing Procedures

***If you are NOT covered by health insurance*:**
Payment is due at the time our services are rendered. We accept cash, checks, MasterCard, Discover and Visa. If you do not pay at the time of service and we are required to bill you, our services are itemized and charged according to our regular fee schedule.

***If you are covered by health insurance*:**
a. Your health insurance coverage is an agreement between you and your insurance carrier(s). We cannot be held responsible for decisions made by your insurance carrier(s) regarding those services that are paid, denied or reduced.
b. We will contact your insurance carrier(s) to verify your benefits. A copy of this verification will be provided to you when it becomes available. This will allow you the opportunity to re-verify and confirm your insurance benefits. We cannot be held responsible for inaccurate, incomplete or misleading information supplied by your carrier(s).
c. From time to time, the benefits associated with your health insurance may change. We cannot be held responsible for claims that were reduced or denied due to suspension, cancellation, change or modification of your health insurance.
d. Some insurance plans may require a referral from your Primary Care Provider. If your insurance plan has this requirement, it is your responsibility to obtain the necessary referral prior to the time of service. If a referral is not obtained, you will be personally responsible for payment of all services that were reduced or denied due to the lack of a proper referral. We cannot be held responsible for reduced or denied claims caused by your failure to obtain a referral.
e. Your insurance plan may require pre-authorization in order for certain services to be considered. If this is the case, we will complete the necessary paperwork and submit this to your carrier for their review and determination. Your carrier may or may not approve the full amount of the benefits we request. You will be personally responsible for payment of all services that were denied or not paid. We cannot be held responsible for reduced or denied claims because your insurance carrier did not authorize them. This is your responsibility.
f. We participate with most, but not all, insurance plans. If your health insurance plan is one with which we participate, we agree to accept your insurance carrier's fee schedule for all covered services. If any of the services you receive are determined to be non-covered, for whatever reason, you will be personally responsible to pay for those services according to our regular fee schedule.
g. In certain situations, your insurance carrier may deny payment or reduce benefits for reasons that seem unfair. We cannot assume responsibility for their decisions. We will fully cooperate with you in the event you choose to appeal an unfavorable determination. However, you are responsible for all current and previously denied fees while an appeal is pending. In the event you receive a reversal of your carrier's original determination and benefits are paid, will promptly refund to you any overpayments that have been made.

***If you were injured in an auto accident*:**
We will accept your auto insurance benefits under PIP (Personal Injury Protection) if your claim is open and benefits are available. It is your responsibility to provide us with all necessary information related to your accident. If an attorney represents you, please provide his/her name and address.

***If you were injured at work or "on-the-job"*:**
We need authorization from your employer in order to treat you unless Leader Heights Spine, Joint & Nerve Associates is designated by your employer as an authorized Workers Compensation provider. Otherwise, you are required to receive treatment from a provider or facility specified by your employer for the first 90 days following the date of your injury.

Other Charges:
Returned checks are subject to a $30 service charge. Balances older than 30 days are subject to collection fees and interest charges of 1.5% per month. Charges may also be made for appointments canceled without 24 hours advanced notice. If you choose to suspend or terminate your treatment, any outstanding fees for our services will be immediately due and payable.

ACKNOWLEDGEMENT, ACCEPTANCE AND AUTHORIZATION: I have read this document and I understand and accept the terms as stated therein. I authorize Leader Heights Spine, Joint & Nerve Associates and/or its assignees to release any and all medical information necessary to process insurance claims for professional services rendered to me or on my behalf, and I authorize payment of medical benefits to Leader Heights Spine, Joint & Nerve Associates for all services rendered to me or on my behalf. I understand that my insurance carrier may in some cases, send payment for such services to me. If this is the case, I agree to forward all checks and copies of the insurance carrier's Explanation of Benefits form that accompanies the checks within five (5) days to Leader Heights Spine, Joint & Nerve Associates.

Patient's Signature (SEAL) ______________________________ **Date**______________________