CENTRAL FLORIDA NEUROSURGERY INSTITUTE

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Central Florida Neurosurgery Institute believes that an important part of good healthcare practice is to establish and communicate financial policy to our patients. We are dedicated to providing the best possible care for you and want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of your visit. We will accept cash or check. Payment will include any unmet deducible, co-insurance, co-pay amount or non-covered charges from your insurance company. If you are not covered by health insurance, or if your coverage is currently limited due to a pre-existing condition clause or ryder on your insurance policy, payment in full is expected at the time of your visit. We do ask for a copy of a valid State or federally issued ID to prevent identity theft. You are always encouraged to ask about our fees before your visit.

2. **INSURANCE** – Our providers participate with many insurance plans. As a courtesy to you, our office will file your primary and secondary insurance claims. A list of the insurance plans we participate with is available upon request. Please remember that insurance coverage is a contract between you, the patient, and the insurance company and ultimately the patient is responsible for payment in full of any monies due. If your insurance company does not pay the practice within a reasonable period of time or denies the bill for an unsubstantiated reason, you will be responsible for the balance due. If we later receive payment from your insurer, you will be refunded any overpayment.

   If our doctors are not participating providers in your insurance plan's network, you may be responsible for partial or full payment. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for your care are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physician participation before your appointment. You are responsible for obtaining a properly dated referral or authorization if required by your insurer and you are also responsible for payment if your claim is rejected for lack of one.

   Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

PLEASE INITIAL THE FOLLOWING

3. _______ **LATE CHARGE** of 12 % annually will be applied to all patient balances older than 30 days but less than 90 days old which have not been placed on a payment plan or settled prior to the 90th day from date of service.

4. _______ **RETURNED CHECKS** will incur a $30.00 service charge. You will then be required to pay via cash, credit or money order to cover the amount of the check plus the service charge.

5. _______ **ACCOUNTING PRINCIPLES** – Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. ________ **FINANCE CHARGES** a monthly finance charge of $5.95 will be assessed to any account placed on a payment plan.

7. ______**COLLECTIONS –** a 35% administrative undisputable charge will be added to your account balance if your account has to be turned over to a collection agency. Accounts that are outstanding for 91 days or more and that are not on a payment plan or have had a lapse of 30 days or more on the payment plan will be turned over to a collection agency.

8. ______**COMPLETING INSURANCE FORMS, COPYING MEDICAL RECORDS, AND COMMUNICATING WITH YOUR INSURANCE CARRIER** requires office staff time and energy. Time and energy which is then not available for patient care for our doctors. We may require pre-payment for completing certain forms, copying medical records, or for extra transcription by the doctors. The charge is determined by the length and complexity of the form or letter.

9. ______**QUESTIONS & CONCERNS** If you have any questions or concerns regarding any of your billing statements, our billing department staff is available to assist you. If you have questions regarding an Explanation of Benefits (EOB) received from your insurance carrier, please call the number on the back of your insurance card. We want to assist you in receiving the care you deserve while ensuring timely and efficient processing of your claims and invoices.

10. _____Patients, who do not meet their financial responsibility to CFNI, do not pay for services rendered or treatment received will be referred to an outside collection agency and their account balance will be referred to CFNI attorney for legal action. Balances under $5,000.00 will be referred the Orange County Small Claims court and balances over $5,000.00 will be referred to CFNI attorney for legal action in the County Court or Circuit Court dependent on the amount of the balance and Florida State law. The patient will also be responsible for any additional fees or costs incurred such as court fees, legal fees, processing fees, and other fees related to pursuing payment.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of patient (or Responsible Party, if minor) Date

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Please print the name of the patient

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Please print the name of the Responsible Party (Attach documentation to file: POA, Custody Forms, Etc.)

Updated: 07-01-14