

NJ Spine Group Financial/Payment Policy

NJ Spine Group, LLC
234 Industrial Way West
Suite A200
Eatontown, NJ 07724
(732) 747-7110

Thank you for choosing NJ Spine Group to care for your spinal problem. We are committed to delivering the finest service available to help you achieve your spinal health goals. Insurance and financial issues may be quite complicated in many cases. To avoid any complications that this may cause with your clinical care, we appreciate you taking the time to read our following policies. Any questions can be readily explained by our staff or administrator. When done, please sign at the bottom indicating that you understand and accept these policies.

1. **Insurance.** For the convenience of our senior patients, we presently participate with Medicare. All other insurance plan participation is variable and doctor dependent. Due to the ever changing state of insurance contracting, even though one of our physicians may have participated in a plan in the past, does not guarantee that they still participate. It is your responsibility to check with this office to determine participation status. If we do not participate with your insurance plan, payment is expected at the time of service until we can verify your coverage. After this time, we will be happy to submit insurance claims on your behalf but you remain responsible for your health care bills. It is your responsibility to understand your insurance benefits. Obtaining a benefit summary from the customer service representative at your insurance company will help both you and us in this effort.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service or, in special cases; arrangements may be made for a payment plan. For your convenience, these charges may be paid by credit card, personal check, or cash. This arrangement is part of your insurance contract and failure to comply may be considered fraud. Please help us uphold the law by taking immediate responsibility for these.
3. **Non-covered services.** Please be aware that some of your services provided may not be covered for payment by Medicare or other health insurers. This does not mean that they are not medically necessary or appropriate. We will always try and forewarn you if this situation arises in your care. Ultimately the cost of these services will be your responsibility.
4. **Proof of Insurance.** All patients are required to complete a full and accurate personal and clinical information form prior to being seen. You must also provide proof of identification (valid driver's license and picture ID will suffice) as well as current valid insurance information (front and back of insurance card).
5. **Claims submission.** As stated above, after insurance verification, we will, as a courtesy, submit claims for you and work diligently to get them paid. Your insurance company may require you to submit some information directly to them. It is your responsibility to comply with their request. Any unpaid claims by your insurance company remain your responsibility so it behooves us to address these issues as quickly and efficiently as possible. If your insurance company does not pay your claim within 45 days, the balance will be automatically billed to you. Even though you have signed an assignment of benefits form for your insurance company, your

insurance company may not honor this and checks may still be delivered to you as the insured rather than to NJSG. If you receive any insurance checks for payment of services rendered at NJSG, payment will become due immediately by you to NJSG. This is most simply done by bringing in the insurance check and endorsing it to NJSG within 5 business days of receiving your insurance payment. Please bring with the check a copy of the explanation of benefits (EOB) report.

6. **Nonpayment.** In case of nonpayment, you, as the receiver of medical care, are ultimately responsible for the bill. By working with the above policies and procedures, we hope to minimize this from occurring. Your insurance company may have a list of what is termed “reasonable and customary” charges for services billed by your health care provider. This list is only a reflection of what the insurance company will cover for this care. It may have little or no correlation to actual charges or any comparable physicians in the area. The potential difference between these charges and any co-insurance will be your personal financial responsibility. NJ Spine Group reserves the right to attempt to resolve all claims through any legal means available. If your account is forwarded to an attorney or collection agency for collection of the outstanding amount due, Patient/Guarantor agrees to pay all collection expenses, fees, costs, and reasonable attorneys’ fees. Patient/Guarantor hereby understands and agrees that if the account is delinquent, Patient/Guarantor may also be charged interest at a rate of 1.5% per month, on the total outstanding balance.

7. **No Insurance.** In the case of a patient having no insurance coverage, payment is due at the time of service. However, we understand that there may be special circumstances that require payment plans. All payment plans will be determined by NJSG administration, in writing, and will be billed to a pre-authorized credit card on a scheduled basis.

8. **Missed Appointments.** Appointments are scheduled to provide efficient and effective spinal care. Missing appointments potentially compromises your care and final results of treatment. Since appointments are scheduled by you at your convenience, we fully expect the courtesy of notice if you cannot make your scheduled appointment. It is also expected that this treatment or evaluation will be rescheduled in a timely fashion so as not to interfere with your care.

9. **Non Sufficient Funds Check.** We will attempt to secure funds from any checks written however, if they are returned unpaid, this amount plus any applicable bank charges will be due immediately.

Sincerely,

Joanne Testa
Practice Administrator

I, _____, have read, understand, and agree to the above financial policies for care at NJ Spine Group.

Patient or responsible party Signature

Date

**Authorization to Use or Disclose Protected Health Information
NEW JERSEY SPINE GROUP, L.L.C.**

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, New Jersey Spine Group, L.L.C. may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

Patient Health Information authorized to be disclosed:

For the specific purpose of (describe in detail)

Effective dates for this authorization: ____/____/____ through ____/____/____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature or Patient or Patient's Authorized Representative *Date*

Authorized Signature of Facility *Date*