Hudson Spine and Pain Medicine
281 Broadway, 2nd Floor
New York, NY 10007
Tel – (646) 596 7386
Fax – (646) 360 2739

OFFICE FINANCIAL POLICIES

1. **PAYMENT** is expected at the time of your visit. We will accept cash or credit card. Payment will include any unmet deductible, co-insurance, co-payment, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. **INSURANCE.** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund overpayment to you.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you. Please contact our office immediately when you receive a check from your insurer.

   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 physicians before your appointment. Many websites have erroneous information and are not a guarantee of coverage. You are responsible for payment if your claim rejects for the 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.

3. **LATE CHARGES** of 12% annually will be applied to all patient balances 90 days old or greater.

4. **RETURNED CHECKS** will incur a $30 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in New York County.

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. **FORM FEES.** Completing insurance forms, copying medical records, etc. requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus and applicable postage or notary fees.

   Postage is additional and payment is required in advance. Copying fees for Medical Records is $10 for the first twenty (20) pages and $0.25 per page in excess of twenty. Hudson Spine and Pain Medicine PC will have 15 business days in which to copy records before making them available for patient pick up, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing records' release.

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7. **BILLING OFFICE.** If you have questions in regard to any of your billing statements, CALL our accounts receivable staff 646-596-7386.

8. **CANCELLATIONS OR MISSED APPOINTMENTS**. If your do not cancel your appointment at least 24 hours before, or if you are a no-show, we will assess you a $25 missed appointment fee.

9. **RESPONSIBILITY FOR PAYMENT**. I understand that I, personally, am financially responsible to Hudson Spine and Pain Medicine PC for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BENEFITS**. I hereby assign, transfer, and set over directly to Hudson Spine and Pain Medicine PC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Hudson Spine and Pain Medicine PC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payment under my policy. I direct the insurance company or health plan administrator to release such information to Hudson Spine and Pain Medicine PC. I authorize Hudson Spine and Pain Medicine PC to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers and any other third-party payers.

11. **RELEASE OF INFORMATION**. I hereby authorize and direct Hudson Spine and Pain medicine PC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

12. **COLLECTION FEES**. I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

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.

SIGNATURE OF PATIENT (or Guarantor, if applicable)	DATE
PRINT PATIENT NAME	