

Sacramento Spine & Physical Therapy

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PAYMENT INFORMATION and AGREEMENT

Welcome to Sacramento Spine & Physical Therapy! Please read the following billing and payment policies carefully. If you have questions about your financial obligations, please let us know immediately.

- **Third Party Payer-Auto/Liens and Legal cases**

1. I am ultimately responsible for all charges. I understand that whether I have an attorney or not, I must sign a lien to cover all outstanding charges not covered by the policy medical payments.
2. I understand that in the event that Medical Payment coverage is exhausted, I will be responsible for all outstanding charges due thereafter. I am responsible for monitoring this status. If you do not understand how to do this, please ask and we will go over this with you. *Initial _____

- **Private Insurance and Medicare *Initial _____**

1. I am ultimately responsible for all of the charges regardless of whether I have insurance or not and I authorize Sac Spine to bill my insurance on my behalf and agree to assign any insurance benefits otherwise payable to me to go directly to Sac Spine for services rendered.
2. I understand that Sac Spine will not accept responsibility for collecting my insurance claim or for negotiating a settlement for me if a dispute arises between my insurance company and me. If such a dispute should arise, I agree to pay the outstanding balance and then pursue reimbursement from my insurance company thereafter.
3. I agree to pay any portion of the bill not covered by my insurance each month, unless contracted rates apply and the charges are disallowed.

- **All patients listed above**

1. Sac Spine will only wait up to 90 days after the date of service for any insurance covered payments that may be due. If the insured has not paid after 90 days, I agree to make arrangements to pay the balance due to Sac Spine and pursue reimbursement from the covering insurance company thereafter or I may be allowed to assign the balance to an attorney lien.
2. If charges remain unpaid after 90 days and I haven't made satisfactory arrangements with the billing office, I agree to pay an administrative service charge of 1 ½% per month (APR 18%) on unpaid balances after 90 days.
3. If any legal action or collections activity is taken by Sac Spine to collect the balance due on my account, I agree to pay reasonable attorney's fees and costs and/or collection fees. *Initial _____

- **Worker's Compensation**

We must receive authorization to treat you within one week from your insurance carrier before we can continue treatment. Reports of your progress and attendance will be submitted to your physician and the carrier/employer and we may need to discuss your case with your carrier/employer or physician.

- **All Patients**

1. When canceling an appointment, I agree to provide at least 12 hours notice, failure to do so will incur a \$20.00 fee. If available, I may be allowed to reschedule the missed appointment within one week to avoid the fee. Insurance companies and worker's comp do not pay for broken appointments; I understand that these charges are solely my responsibility. *Initial _____*
2. We do not require a physician referral in order to provide your rehab. However, many insurance companies will not pay for services without a physician referral. We will be happy to recommend a physician to all patients who do not have one.

I have understood and agree to the above payment contract. A copy is as valid as the original.

Date: _____ **Signature of responsible party:** _____