Financial Policy

We, at Delta Spine and Pain Clinic, are committed in providing the highest quality of care for our patients and are happy to discuss professional fees with our patients at any time. The intent of this letter is to inform you and not to alarm you of the financial process and fees incurred for services rendered.

As you are aware, there are many different fees associated with providing medical care and many times those services are separate entities requiring separate charges. For instance, the doctor who performs the surgery is a separate service provider than the anesthesiologist who provides anesthesia; therefore, there may be two separate bills.

Even if you have insurance coverage, there may be fees that become the responsibility of the patient. You are responsible for denied charges, amounts applied to the deductible, and fees considered a co-payment, fees considered co-insurance or any amount considered non-covered by your insurance plan. For example, after paying the deductible, co-insurance and/or co-pay, you may still have a remaining balance left that needs prompt payment in full.

It is up to you to determine whether you are covered for the services planned or provided. We do, however, offer information regarding the coverage of proposed or received service and your financial responsibility, but ultimately it is your duty to obtain the up to date information. Please contact your insurance company for covered services, network participation, or other pertinent questions.

On occasion, the quoted fees may be less or more than the actual charges incurred. In other words, sometimes the payment statement may not exactly match for multiple reasons although the estimates generally are the billed amount. It may take up to 3 to 6 months or longer for you to receive the final payment statement for processing through all the parties involved.

Assignments of Benefits:

I hereby authorize the release of any information necessary to process insurance claims associated with any medical treatment performed by Delta Spine and Pain Clinic. I authorize payment directly to Delta Spine and Pain Clinic consultants for any medical benefits due me for services performed by this clinic or its physicians. I understand that I am responsible for all non-covered services or applicable coinsurance and deductibles. I also understand that I am responsible for clinic or provider's charges that may exceed the insurance allowance depending on my insurance coverage.

Payment guidelines:

We expect FULL payment at the time of service if you do not have insurance.
Co-payments must be paid at the time of service as required by your insurance company.

Co-insurance and/or deductible will be billed to you after the date of service post processing of the claim by the insurance company.
We accept VISA, MasterCard, checks and cash.

Under-aged Patients:

If the patient is under age 18: I, _____, the caretaker/responsible individual, give permission for my child _____ to be treated by Delta Spine and Pain Clinic or its associates.

We are willing to work with you in arranging an agreement if you are having financial difficulties for the provided service.

Please feel free to discuss any concerns or questions. It is ultimately your responsibility to find out the distribution of bills and charges that will be incurred including your responsibility of that amount. We will make every effort to minimize misunderstandings and through open communication with you, come to a mutual agreement. Please be understanding and be patient through the process. Thank you for allowing us to be part of your medical care.

_____ _____

Signature Date