THE SPINE & HEALTH CENTER OF NEW JERSEY

PAYMENT POLICIES/ASSIGNMENT OF BENEFITS

We are committed to providing you with the best possible care. Please read carefully and sign at the bottom of the page indicating your acceptance of our policies and procedures.

1. PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE.
   a. Your insurance is a contract between you, your employer and the insurance company. We are not included in your contract.
   b. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover
   c. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.
   d. If your account becomes past due and goes to our collections agency, you are responsible for all fees incurred.
2. OUR OFFICE PRIDES ITSELF ON OUR ABILITY TO SEE PATIENTS IN A TIMELY MANNER.

THEREFORE, WE REQUIRE 24 HOURS NOTICE FOR ALL CANCELLATIONS. THERE WILL BE A $25.00 NO-SHOW OR SAME DAY CANCELLATION FEE.
REPEATED SAME DAY CANCELLATIONS OR NO-SHOWS WILL REQUIRE US TO TAKE A $49 HOLD FEE VIA CREDIT CARD WHICH WILL BE CHARGED AT THE TIME THE APPOINTMENT IS MADE IN ORDER TO BOOK ANY FUTURE APPOINTMENTS. THIS $49 WILL BE CREDITED TO YOUR ACCOUNT (CO-PAY, DEDUCTIBLE, NON-COVERED SERVICE) AFTER YOU COME IN FOR THE APPOINTMENT.

1ST CANCELLATION: $25.00 CANCELLATION OR NO-SHOW FEE.
2ND CANCELLATION: $25.00 CANCELLATION OR NO-SHOW FEE
3RD + CANCELLATION: $49 HOLD FEE TO BOOK FUTURE APPOINTMENTS (CREDITED TO PATIENT ACCOUNT AFTER VISIT)

3. I HEREBY INSTRUCT MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT TO THE SPINE AND HEALTH CENTER OF MONTVALE.
   a. This is a direct assignment of my rights and benefits under my health insurance policy.
   I agree to pay any balance of professional services charged over and above this insurance payment.
   b. If my current policy prohibits payments directly to the doctor, I agree to mail the check (original or personal) as payment for services rendered.

4. I HAVE RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient/Policy holder signature **Date**