CSNA
neurosurgery & neurology

Penrose Pavilion
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Colorado Springs, CO 80907

719-473-3272 **PH**
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FINANCIAL POLICY

Welcome to our practice. We are committed to giving you the best medical care. In return, we expect that you have the same commitment to your medical care and your financial responsibility associated with this care.

As a courtesy, CSNA will file your insurance claim, however, it is your responsibility to know your insurance company's requirements. Please verify with your insurance company that the doctor you are scheduled to see is participating with your insurance. We accept cash, checks, credit cards (Visa, MasterCard and Discover) and CareCredit. A $28.00 service charge is assessed for all returned checks. Any accounts not paid in full within 60 days of your first statement may be considered for collections and subject to applicable fees.

AUTO We will bill your auto insurance for you, however, your auto insurance may not pay us directly. If direct payment is not received you are responsible for payment.

CONTRACTED HMOs and PPOs You are responsible for any applicable deductibles or co-insurance amounts. Co-payments are due at the time of service. Services not covered by your plan will be billed to you. Referrals are your responsibility. If a referral is not in place, your appointment will be rescheduled.

INSURANCE WE DO NOT PARTICIPATE WITH As a courtesy we will file your insurance for you. If your insurance has not paid within 60 days, you will be expected to pay your account in full.

MEDICAID A referral from your primary care physician and a copy of your current card are required before services can be provided. If either or both are missing, your appointment will be rescheduled.

SELF PAY You are required to pay for each visit in full at the time of services. If you have any questions, contact our financial office at 719-389-1137.

WORKERS COMPENSATION If your injury is work related, we need the carrier name, address and case number prior to your visit. If you do not provide us with this information, you will be responsible for the charges incurred at the time of service. If this is a Federal workers compensation claim, please provide us with the Letter of Acceptance at the time of your appointment.

ANCILLARY SERVICES With the numerous managed care plans and the ever-changing participating providers for radiology, laboratory, surgery centers, physical therapy and hospitals, it will be your responsibility to know which facility you are required to use. If you are unsure call your insurance company.

RELEASE OF INFORMATION I hereby authorize the release of medical records and/or statement of account to my insurance company in order to determine benefits for services rendered.

ASSIGNMENTS OF BENEFITS I hereby authorize direct payment for medical and/or surgical services to CSNA. This authorization will remain in effect until revised by me in writing. A copy of this authorization will be considered as valid as the original. I understand I am financially responsible for all charges, surcharges, and attorney's fee, whether or not they are paid by my insurance. I hereby authorize the above listed provider to release all information necessary to secure payment.

CONTINUED ON BACK

NO SHOW/CANCELLATION We will confirm your appointment 3 days and 1 day in advance. If your schedule changes, please call our office prior to 24 hours out from your appointment to cancel. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting needed treatment. If an appointment is not cancelled at least 24 hours in advance or if you fail to show up for your scheduled appointment you will be charged a $25 fee. This fee will not be covered by your insurance company and is required to be paid when you schedule your next visit. Please be aware two no show appointments with any practice provider within a rolling 12-month period may result in not being seen by CSNA for one year from the date of the last no show.
Patients that no show for a scheduled EMG or EEG will be charged $150.00.

Copays are due at time of service

I have read and I understand the above financial policy. I accept responsibility for all fees mentioned within.

Signature_____Date_____