ADVANCED SPINE AND BRAIN CENTER
An affiliate of Liberty Hospital

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Financial Policy

1. Fees are due and payable at the time of your appointment. If we are contracted with your insurance, you will be billed any remainder after we hear from them. As a courtesy, we accept cash, checks, Visa, Discover, and Master Card.
2. If you have an HMO or PPO insurance with a designated primary care physician, please make sure you have selected a physician in our office. If you present us with the incorrect insurance card or information, you will be required to pay the entire fee including any lab services.
3. All co-pays must be paid at the time of your service
4. Not all services are a covered benefit in all contracts. If you have a question regarding benefits, you need to call your insurance company prior to your office visit and check your benefits. Your insurance policy is a contract between you and your insurance company.
5. All services must be paid in full within 30 days after your insurance has paid their portion. If your visit is due to a Motor Vehicle Accident, payment in full is due at the time of the service.
6. The person who brings a child for care is ultimately responsible for their bill. The physician will not get involved in court decisions or support disputes.
7. Accounts become past due after 30 days. We reserve the right to send an account to collections if not paid in full
8. All returned checks must be paid with cash or money order within 5 working days or they will be turned over to the prosecuting attorney's office.
9. If you have any questions, please call our billing office at 816-407-4200.
10. All deductibles and co-payments for Obstetric (OB) services must be paid in full by the 7th month with regular payments due each month by cash, check or credit card.

I hereby acknowledge that I have read, understand, and agree to the terms of this document relating to insurance coverage and payment of my bill.

PATIENT/GUARDIAN'S SIGNATURE _____ PRINT PATIENT'S NAME & BIRTH DATE _____ DATE _____

Signature On File

I authorize use of this form on all my insurance submissions. I authorize release of information to all of my insurance companies. I authorize direct payment to Advanced Spine and Brain Center. I permit a copy of this authorization to be used in place of the original. I understand I am financially responsible for all charges whether or not covered by insurance.

SIGNATURE _____ DATE _____