Athens Spine Center, PC
830 King Avenue
Athens, GA 30606-2889
(706) 425-2400 - PHONE
(706) 425-2410 – FAX

Athens Spine Center Financial Policy

Thank you for choosing Athens Spine Center, PC as your health care provider. We are committed to providing you with quality and affordable healthcare. The following Financial Policy outlines both Patient and Insurance responsibilities for services rendered. We ask that you read and sign the following policy and if you have any questions to please ask us.

Insurance: We participate in most insurance plans including Medicare. Currently, we do not accept Medicaid as Primary Insurance. As a courtesy we will try and verify eligibility and obtain any necessary prior-authorizations, however, this does not guarantee reimbursement. It is the responsibility of the patient/responsible party to provide us with up-to-date current insurance information and to make sure that we are in-network with the plan.

Notification of any changes in insurance must be reported prior to your next appointment. This is so that we can make the necessary changes and make sure that all necessary approvals have been received.

All patients will be required to provide a copy of their driver’s license and a current valid insurance card. If you fail to provide us with the correct current insurance information, you may be responsible for the balance of the claim.

Billing/Claim Submission: We will submit a medical claim on your behalf for your visit or procedure and assist in any way to help get the claim(s) paid. Your insurance company may need you to supply additional information directly. It is your responsibility to comply with this request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays the claim. Insurance claims over 90-days will become the responsibility of the patient.

Co-payments and Deductibles: Once we receive notification from your insurance company of your portion, we will send a statement that alerts you of your current balance (this could be paper, text, email, or other means of communication).

Any copays and remaining balances from previous appointments are due at time of service. We accept Cash, Checks, MasterCard, Visa & Discover Card.

If you are not covered by health insurance, you will be required to pay your bill in full prior to your appointment.

Non-covered Services: There are some services that are offered that are either not covered or not considered medically necessary by insurance. These services must be paid for in full at the time of service. These services will NOT be billed to your insurance. You will be made aware of these services prior to scheduling.

Card on File: We have implemented a Card on File Policy that allows for patients to maintain credit card information on file in our office. This information will be held securely until your insurance provider has paid their portion of your bill. At that time, you will be notified of any outstanding balance and that your credit card will be charged in a specified number of days. You may call our office if you have questions

Athens Spine Center, PC
830 King Avenue
Athens, GA 30606-2889
(706) 425-2400 - PHONE
(706) 425-2410 – FAX

about your balance or do not wish to use this feature at this time. A receipt will be sent to you once the balance has been processed.

Nonpayment: We will attempt to work with you regarding your account balance. If we cannot obtain your cooperation, we reserve the right to refer your account to a Collection Agency once the account is 90-days past due. The patient/responsible party also consents to receive calls on any cell phone number that is provided to the Collection Agency. Once the account has been referred to a Collection Agency you may also be discharged from the practice until that balance has been paid in full.

Returned Checks: There is a $35.00 fee for any returned checks. If we receive a returned check, you will no longer be allowed to use checks as a method of payment.

Missed Appointments: A $50.00 fee will be assessed for all missed appointments and any appointment not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. This will be due prior to your next appointment. Failure to keep multiple appointments may result in you being discharged from the practice.

I have read, understand, and agree with the Financial Policy. I understand that charges may not be covered by my insurance company, and all applicable co-payments, co-insurance, and deductibles are my responsibility. I understand that failure to pay my account may result in the account being forwarded to a Collection Agency and restrict the scheduling of future appointments.

I understand that typing my name on the signature line below, I am agreeing to the use of an electronic signature. This signature serves as an affirmative indication that I have carefully reviewed and consented to all the terms outlined in this agreement.

Signed by: ___________________________________ Date Signed: _________________________
Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative: _____________________________________