Financial Agreement

(All patients)

Copays

Many insurance plans require that patients pay a copayment at the time of service. We are not allowed to defer, waive, or disregard these payments. We accept VISA, MasterCard and personal checks. Returned checks will be charges an additional fee of $25.

Accounts past due

If a payment to your account is not received after 3 billing cycles, your account will be turned over to a collection agency. You will be responsible for the outstanding balance and the legal and collection agency fees associated with the collections process. All delinquent accounts can bear interest at the legal rate.

Release of information/Assignment of Benefit Statement

"To the extent necessary to determine liability for payment and to obtain reimbursement, East Bay Neurosurgery and Spine, Inc. may disclose portions of the patient's record, including his/her medical records to any person or corporation which is or may be liable for all or any portion of the charges, including but not limited to insurance companies, health care service plans, or workers compensation carriers. The undersigned also authorizes all federal, state and local government agencies, insurance companies, and employers to release any and all information regarding the patient to the office or its agents.

The undersigned authorizes, whether he/she signs as agent or as patient, that in consideration of the services to be rendered, he/she hereby individually obligates himself/herself to pay the account of East Bay Neurosurgery and Spine, Inc. in accordance with the regular rates and terms of the office.

I certify that the information given to me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be paid on my behalf."

________________________________ ________________________

Patient/Parent/Guardian Signature **Date**

Medicare Extended Authorization

(Medicare patients only)

I request that payment of authorized Medicare benefits be made on my behalf to East Bay Neurosurgery and Spine Inc. for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature below requests that payments be made and authorizes release of medical information necessary to pay the claim. If item 13 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

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Print Name **Medicare Number**

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Signature **Date**