Center for Neurosurgical and Spinal Disorders

1614 Wolf Circle
Lake Charles, LA 70605
Telephone (337) 478-9653 • Fax (337) 474-0988

Financial Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. PLEASE understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist.

If you have a ***Commercial Insurance/PPO plan*** *with which we have a contract* and the services you received are covered by the plan then all patient responsibility amounts are requested at the time of the visit. This includes co-pays, deductibles and non-covered services. Our staff will contact your insurance company ahead of time to determine deductibles and coinsurance. We will file an insurance claim as a courtesy to you.

If you have a Commercial, PPO, or HMO plans with which we are ***NOT*** contracted, then payment must be made in full for office visits, injections, and other charges at the time of service. Our staff will provide the necessary information for you to file your claim directly with your insurance company.

If you have regular ***Medicare***, and have not met your $140 yearly deductible, we ask that it be paid at the time of service. You may be asked to sign an Advanced Beneficiary Notice (ABN) if Medicare does not provide information of coverage for the services you are to receive. If it is known that Medicare does not cover the procedure, then a payment is required in full at the time of the visit. If you have regular Medicare as primary with a secondary insurance / supplemental plan then no payment is necessary at the time of the visit. If you have regular Medicare only, then your 20% co-pay is required at the time of the visit. Our staff will file the claim on your behalf, as well as any claims to your secondary insurance.

If you do not have insurance, then payment is expected in full at the time of service. Our office will work with you to settle your account. Please ask to speak with our staff if you need assistance.

The Surgery Coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. The Surgery Coordinator will explain a cost estimate, which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan. The surgery charges will include Dr. Wolf's fees along with a fee for a surgical assistant, which will be billed by this office. Additional charges incurred at the time of surgery will include, but are not limited to, the hospital bill, radiologist, pathologist, and anesthesiologist fees.

If you disagree with the payment made by your insurance carrier, please contact the insurance company directly to discuss those concerns. Your insurance contract is an agreement between you and the insurance company, and as the subscriber, you are responsible for the terms of that agreement.
We understand that many of our patients experience financial difficulties. If this is the case, please let us know so we can assist you in making budget payment arrangements ***prior to*** the time of service. If you would like to discuss your account, please do not hesitate to contact us at (337) 478-9653, between 8:00am and 5:00 pm Monday through Thursday and between 8:00am and 12:00pm on Friday.

FINANCIAL POLICY

Patient's or Authorized Person's Signature

I, _____, authorize this facility to examine and provide medical treatment. I assume full responsibility for any balance due. Any remaining balance due by the patient is to be paid within 90 days from date of service. Upon default of payment, I agree to pay Center for Neurosurgical and Spinal Disorders, LLC for all costs associated with the collection of the balance.
I authorize my insurance company to pay by check made out directly to this facility. I authorize this facility to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

I have read, understand, and agree to the above Financial Policy.

_____ _____

Patient or Responsible Party Signature **Date**

Please list the MAIN reason you are seeing the healthcare provider today?

Is this due to a car accident, work related injury, or liability case? _____