NSSC Spine Clinic
Neuroscience & Spine Center of the Carolinas

Neurosurgery
William D. Hunter, MD
Megan H. Wilkinson, ACNP- BC
Temeshia L. Spikes, FNP- C
Misty N. Partin, ACPCNP-BC

Financial Policy

Name: _____ Acct: _____

NSSC Spine Clinic, The Office of Dr. William Hunter, believes that part of a good health care practice is to establish and communicate a financial policy to our patients. An informed and responsible patient should never have a credit problem with our practice.

1. **Payment** is expected at the time of your visit. We accept cash, check, Visa, Mastercard, Discover or American Express.
2. **Payment** will include any unmet deductible, coinsurance, copay amount, or charges that are not covered by your insurance company.
3. **Pre-payment for Surgery –** Our office will collect the anticipated patient responsibility for surgery at the pre-operative appointment. If payment in full is not possible, a Payment Agreement MUST be made with the billing department prior to your surgery date except in the case of an emergency. All pre-payments must be made with cash, money order, or credit card.
4. **Returned checks –** will incur a $35 service charge. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge.
5. **Accounting principles –** Payments and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding charges.
6. **Refunds** will not be issued automatically for $10.00 or less. Patient or patient's representative must contact our billing department and request such a refund.
7. **Disability forms, insurance forms, copies of medical records, etc** require office staff time away from patient care for the doctors. We require pre-payment for completing forms, copying medical records and for extra transcription by the doctors. The charge is determined by the length and complexity of the form/letter.
8. **Collections**-Patients whose accounts have been turned over to a collection agency will be responsible for the account balance and all costs associated with collection, including reasonable attorney fees.

If you have any questions after reviewing our policy, please ask to speak to someone in the billing department to avoid any misunderstanding. By signing my name below, I agree:

A. I have read and understand the NSSC Spine Clinics financial policy.
B. I hereby authorize the release of medical information to my insurance carriers concerning any medical condition and treatment.
C. I assign to NSSC Spine Clinic all payments from my insurance carrier for medical services rendered to myself and/or my dependents.
D. I fully understand that I am financially responsible for any copays, deductibles, coinsurance, or services that are not covered as determined by my insurance carrier.
E. You agree, for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us. Methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automatic dialing device, as applicable.
F. I/We have read this disclosure and agree that NSSC Spine Clinic or Online Information Services may contact me/us as described above.

Payment will be collected at the time the services are rendered.

Signature: _____ Date: _____