CENTER FOR NECK AND BACK PAIN

INSURANCE COVERAGE

The following policy applies to patients with insurance coverage, provided that Center For Neck and Back Pain has agreed to accept assignment on your case. It is not the policy of Dr. Douglas Herting to accept assignment on patients with insurance. Our policy is to be paid in full at the time of service. However, we will accept assignment when there is an inability to pay in full by the patient or if we have an agreement with the insurance carrier to do so.

By signing this form, you agree to comply with all the policies outlined below.

1. The patient, or the person financially responsible for the patient, hereinafter referred to as " patient" agrees to furnish Center For Neck and Back Pain with all pertinent information required by the insurance company, so we can bill them in a timely fashion and receive prompt payment. Until you have filled out the Insurance Verification Form and returned it to this office, you will be responsible for paying for your own care at each visit including the first visit. Once you return the form and your coverage is verified, we will credit the amount you have paid to your portion of the bill. If any insurance patient becomes involved in a workers compensation or personal injury claim, any pricing structures under the patient's medical plan no longer apply according to California State Law.

2. The patient agrees that though we are accepting assignment from the insurance company, they still have final responsibility of any amount owing. If, for any reason, the insurance company refuses to pay any portion of the bill, the patient will pay the amount owed in full at the time the insurance company advises non-payment.

3. The patient agrees to pay the deductible, and/or the co-payment in full at the time of the visit to our office. Also, the patient agrees to have a valid credit card number on file with Center For Neck and Back Pain at all times, and authorizes Dr. Douglas Herting to use the credit card number for payment, if the amount owing is not paid in full at the time of the visit to our office. Furthermore, it is agreed that should the insurance company not pay a billing for any reason, Dr. Douglas Herting is authorized to use the credit card number for payment of any amount owing from the outstanding insurance billing. Payment from the insurance company is expected within 60 days from the billing date. Any insurance balance owing beyond the 60 days will automatically be transferred to your personal balance. Dr. Douglas Herting will notify you of any outstanding insurance billing amount, and will give you 7 days to make a payment in full, before utilizing the credit card number for payment.

4. Occasionally, an insurance company accidentally sends a check to the insured, rather than to Dr. Douglas Herting. Should this occur, you agree to bring the check, **with the stub attached, and any other paperwork sent to you within 7 days of receipt,** to Dr. Douglas Herting to apply to your outstanding balance. Furthermore, the insurance company occasionally requires additional information from you. You agree to promptly furnish any information requested, to insure that payment does not get delayed.

5. If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by you or your insurance company will become immediately due and payable by you personally before you leave.

6. Dr. Douglas Herting does not extend credit. Should any amount due not be paid in full in the timeframe agreed upon, we will begin assessing late fees on the amount due at a rate of 1.5% per month. Any returned payments will be assessed a $15 service fee which will be added to the outstanding bill. As well, Center For Neck and Neck Pain requires the social security number of the person who is financially responsible for the patient. Center For Neck and Back Pain will hold this information in the strictest confidence, and will only utilize it in the event of delinquency in payment, or for any court action required to collect any amount owing on the patient account.

By signing this agreement, you agree that you have read and understood the above.

_____
Signature of the financially responsible party

_____
Date

_____
Print name of financially responsible person

_____
Social Security # of financially responsible person

_____
Visa, MasterCard, American Express, card number of the financially responsible person

_____
Patient Name (if other than financially responsible person)

_____
Expiration Date

_____
Witness

_____
Date