COLORADO CENTER FOR SPINE MEDICINE

4820 Riverbend Rd. 2nd Floor Boulder CO 80301

#303-444-2955 Fax# 303-889-5103

The following policy applies to all providers of Colorado Center for Spine Medicine, LLC.

Our Policy of Payment

Insurance

• Your insurance policy is a contract between you and your insurance company. We are not a party in that contract. We are **not** contracted with **Medicaid**.

• We will file your insurance claim two times, if necessary. If it is denied, it will be your responsibility to follow up with your insurance company to resolve the claim.

• Not all services are a covered benefit in all insurance contracts. *All charges are your responsibility whether your insurance company pays or not.*

• **Co-pays must be paid at the time of your appointment.** *If you are unable to pay your co-pay you may reschedule your appointment.* Any returned or cancelled checks will be subject to a **$50.00 cancellation fee**. Cancellations must be made 24 hours in advance or a **$50.00 no show office visit fee & $150.00 no show injection fee** will be charged.

• Accounts become past due 30 days after your insurance pays. Statements are sent out weekly and the balance is due within 10 days of receipt. We reserve the right to send the account to a collection agency if the balance is not paid in full 45 days after your insurance pays its portion.

• In the event of your non-payment, you agree to pay, whether or not legal proceedings are instituted, a reasonable *collection agency fee* which shall be 35% of the principal balance for any debt incurred hereunder and to pay all reasonable costs of collection including but not limited to *court costs, attorney fees and interest* as a result of your default.

Cash Patients

• All cash patients must pay the cash fee at the time of service or be rescheduled for a later date.

Payment Options

We accept cash, check, money order, Visa, MasterCard, Discover or American Express for payment.

I hereby acknowledge that I have read, understand, and agree to the terms of this document relating to insurance coverage and payment of my bill.

Patient Name (printed): _____

Patient or Representative Signature: _____ Date: _____

Relationship of Representative: _____