Physicians Plus Spine & Rehab Center
1701 Pulaski Hwy Bear, DE 19701
P.) 302-300-1111
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Our Financial Policy

Thank you for choosing Physicians Plus Spine and Rehab Center LLC. as your healthcare provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff. We ask that all patients read and sign Our Financial Policy, as well as complete our Patient Information Forms prior to seeing the doctor.

As a service to you, we will process your insurance claim for you. **By signing this form, you are assigning your benefits from your carrier to Physicians Plus Spine and Rehab Center so that the physician will be reimbursed directly for the services rendered to you. Your patient responsibility will be due at the time of service.** As we do accept your assignment of benefits, you must understand that:

1.) Your insurance policy is a contract between you, your employer, and/or the insurance company. We are not a party to that contract. Our relationship is with ***you***, not your insurance company.

2.) It is your responsibility to know your benefits and to obtain any authorization/referrals that are required for services provided. All charges are your responsibility whether your insurance company pays or not. Any services not covered by your benefits or any plans that our office does not participate with are your responsibility and payment is expected at time of services. We encourage you to review your policy guidelines to be sure of your coverage.

3.) Fees for these services, along with unpaid deductibles, coinsurance, and co-payments, will be due at time of service. You will be responsible for all attorney fees or collection fees related to the collection of your account.

4.) If the insurance company does not pay your balance within 30 days, we ask that you contact the carrier to help speed things up.

5.) If the insurance company does not pay your balance due within 90 days, we may then require you to pay the balance due, and you may seek reimbursement from your insurance carrier.

6.) We will prepare any necessary reports and forms needed to help assist in collecting payment from the insurance company and any amount authorized to be paid will directly to Physicians Plus Spine and Rehab Center and a credit will be added to your account with our office. If payment is sent to you from the insurance company instead of our office than you are responsible for that balance upon receipt of said payment.

7.) If your treatment is related to a personal injury case (motor vehicle accident) or work related injury, we understand that legal action by your attorney can often extend for some time. In this instance, we will be willing to waive payment from you until settlement. Please be aware that it is your responsibility to provide our office with complete billing information, (insurance carrier's name, full address/ claim number, and adjuster's name and phone number). We will not hold a balance without a signed, by both parties, ***LIEN ASSIGNMENT – LETTER OF PROTECTION*** on file.

Again, thank you for choosing Physicians Plus Spine & Rehab Center as your healthcare provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Authorization and Release of Information: A photocopy of this assignment shall be considered as effective and valid as original. I understand and agree to authorize the release of any information that Physicians Plus Spine & Rehab Center deem appropriate or pertinent concerning my physical condition and/or case to any insurance company, attorney, or adjuster involved with this case. I also authorize the release of any information pertinent to process any claim for reimbursement of charges incurred by me because of professional services rendered by you (Physicians Plus Spine and Rehab Center, including designated associates and assistants) and hereby release you of any consequence thereof.

Insurance Assignment: I hereby authorize and direct all payments for medical services rendered to myself or my dependent payable to Physicians Plus Spine and Rehab Center. I understand that I am responsible for any amount not covered by insurance. I authorize the use of my signature on all insurance submissions.

Insurance Authorization: I hereby authorize Physicians Plus Spine & Rehab Center to file a formal written complaint with the Insurance Commissioner when necessary.

HIPPA Policy: My signature below confirms that I have been made aware of the Notice of Privacy Practices and can be provided a copy upon request.

_____ _____

Patient's Name Date

_____ _____

Signature Signature of Parent or Guardian (if a minor)