Pt Name
MR #

Grand Strand
Regional Medical Center
Spine & Neuro Center

FINANCIAL POLICY

TO OUR PATIENTS:
It is important that our patients understand that we value our relationships and will work with you to achieve payment from the responsible party for all services rendered. In consideration for the medical care to be provided to the Patient, the undersigned Patient, guarantor and/or responsible party (collectively referred to as “the Patient”) hereby consent to Grand Strand Spine & Neuro Center (“the Practice”) financial policy. By signing below, the Patient agrees and consents to the following financial policy:

1. Payment for all services is due at the time of service unless the Practice is a participating provider with the Patient’s health insurance company or the Patient has an authorized Worker’s Compensation case. This is contingent upon the Patient providing the Practice accurate and complete information concerning insurance coverage and authorization at the time of service. All patients are responsible for payment of their coinsurance, deductibles and any co-payments at the time of service.
2. Patients who fail to present accurate insurance information are solely responsible for all charges incurred.
3. If the Practice does not participate with the Patient’s health insurance company, the Practice will file the initial claim as a courtesy to the Patient. The Patient is responsible for payment at the time of service. It is the Patient’s responsibility to collect payment from their health insurance company.
4. If the Patient agrees to have services provided that is not covered by their insurance plan, the Patient may be asked to sign a form wherein the Patient agrees to accept financial responsibility. If the services rendered are not covered by the Patient’s health insurance company, payment is due at the time of service.
5. The Patient will receive a bill for any remaining balance after the Patient’s health insurance company has paid their share. All patient balances are due and payable in full within 14 days after receipt of the statement.
6. Pursuant to South Carolina law, unless a minor is emancipated, patients 18 years of age or older are financially responsible for the total charges incurred.
7. The undersigned agrees that if this account is not paid timely, it may be turned over to a collection agency or attorney, and in such circumstances, the Patient, shall be obligated to pay the amount due plus all costs of collection including reasonable attorneys’ fees. The undersigned agrees that overpayment collected on this account may be applied directly to any delinquent account(s) of the patient. The undersigned Patient, responsible party and guarantor, if any, hereby agree that they are jointly and severally liable to pay the Practice for any and all charges, and costs associated with this treatment.
8. A $50 returned check fee will be assessed for every check that is returned as non-payable.
9. Refunds due to Patients will be issued on a monthly basis. Refunds will be given in the form of a check.

I have read the entire document and accept and understand its terms. I also certify that I am the patient, am duly authorized by the Patient, or am duly appointed to execute this agreement and accept and understand its terms.

____ __________________________
Signature of Patient/Guardian/Responsible Party Date

____ __________________________
Witness Signature Date