COR Spine and Pain Center
6255 Sharlands Avenue • Reno, Nevada 89523
Office: (775)248-1267 Fax: (775)305-1267
Email: contact@corspine.com Website: www.corspine.com

STATEMENT OF FINANCIAL POLICY AND FINANCIAL RESPONSIBILITY

Thank you for choosing COR Spine and Pain Center as a partner in your medical care. In order to provide you with a full understanding of your financial obligations, an important aspect of your medical care, we have developed the following policies:

All patients are financially responsible for services provided.

- Our office requires that you provide a copy of your current insurance card and photo ID at every visit.
- As a requirement of both our office and your insurance company, co-payments are due at the time of service.
- Payment of co-insurance or any charges not covered by your plan is required at the time of service.
- Medicare recipients are expected to update the National File with any changes by calling 1-800-MEDICARE.
- Payment is required in full at the time of service from uninsured patients unless arrangements have been made in advance.
- If previous arrangements have not been made, any account balance over 90 days will be turned over to a collection agency.
- A fee of $25 will be charged to you for returned checks, plus any bank fees incurred.

Referrals/Authorizations

It is the patient's responsibility to ensure that any referrals or authorizations for treatment are provided to the office prior to your appointment. If the authorization or referral is not obtained prior to your visit, you will be expected to pay for all charges at the time of your visit.

Financial Agreement

I agree, whether signing as a patient, parent, guarantor, or agent of the patient, that in consideration of the services provided by the provider to the patient, I will promptly pay all bills in accordance with the providers standard of charges for such services, as well as, in accordance with applicable federal and Nevada State Laws and regulations. Should my account be referred to an attorney or collection agency, I will pay actual attorney's fees and collection expenses.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about our Financial Policy should be directed to the front desk personnel.

I have read and understand the Financial Policy and agree to comply and accept responsibility for services provided by COR Spine and Pain. I understand that I have a right to request an explanation of the Provider's billing process and a list of the Provider's charges for any service(s) I might receive.

COR Spine and Pain Center
6255 Sharlands Avenue • Reno, Nevada 89523
Office: (775)248-1267 Fax: (775)305-1267
Email: contact@corspine.com Website: www.corspine.com

I have read and agree to the above terms of the Statement of Financial Policy and Financial Responsibility:

Name of Patient (Please Print)**:** _____

Patient Signature: **Date:** _____

_____

Name of Parent/Legal Guardian (if applicable, Please Print)**:**

_____

Relationship of Parent/Legal Guardian to Patient (if applicable)**:**

_____

Parent/Legal Guardian Signature: **Date:** _____

_____