

California Spine Diagnostic Medical Group
Conor O'Neill, M.D.
2100 Webster St, Suite 110
San Francisco CA 94115
(415) 600-7830

Our Financial Policy

We thank you for choosing **California Spine Diagnostics** for your interventional pain services. Please understand that payment of your bill is an essential part of our financial relationship. In the course of your treatment, you may receive separate bills – **the physician's professional services, the facility, imaging services and tests, or laboratory tests**. The following is a statement of our physician's financial policy which we require you to read and sign prior to services rendered.

Medicare

We are a participating Medicare provider. You are responsible for your deductible and co-payment. If you have a secondary carrier, a portion of your co-payment may be covered.

Appointment Cancellation Charge

A full appointment fee may be charged for appointments or procedures cancelled without a minimum of two business day's notification. (Please Initial: _____)

Non-covered Services

If we provide services to you that are not covered by your health plan, you will be responsible for payment in full for those services. Your signature, below, constitutes agreement to pay for such services.

Co-Payment and Deductible

Your insurance may pay for this service, and frequently your insurance only pays a portion of the bill. You are responsible for your co-payments and deductible. Your co-payment is due at the time of service. You are responsible for any remaining balance that is not covered by your insurance. This balance is due within 30 days.

Payment Arrangements

Payments may be made in cash, by check or by VISA/MASTERCARD/American Express.

Assignment of Benefits

The undersigned assigns and hereby authorizes direct payment to the California Spine Diagnostic Medical Group, Inc. of all insurance and plan benefits otherwise payable to or on behalf of the patient for services rendered. It is understood that he/she is financially responsible for charges not covered by this assignment.

Collections

If it is necessary to assign your account to a collection agency and/or attorney, you will be responsible for all of our collection agency and attorney fees.

Release of Information

I authorize the release of any medical or other information necessary to process my health insurance.

Responsible Party Signature _____ Date _____

Printed Name _____

Consent for Use and Disclosure of Health Information

You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this Consent. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely. By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Patient Signature _____ Date _____

Printed Name _____