PATIENT FINANCIAL RESPONSIBILITIES

Neurosurgery and Spine Northwest is committed to providing the highest quality of caring, compassionate and comprehensive neurosurgical care available in the inland northwest, including your pre-treatment planning, clinical and surgical services, and the billing/payment process. It is important that you understand your financial responsibilities for the services you receive. The changing healthcare environment puts more of this responsibility in your hands. Your health insurance is a contract between you and your insurance carrier. We are providers for most major insurance companies. You are required to obtain any necessary prior authorization prior to your appointment to receive maximum coverage for our services. Your responsibilities are outlined below. Please read, initial each section, and sign below indicating your understanding and consent to our policies. Our billing office is available to assist you should you have any financial concerns regarding your care.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I assign to William F. Ganz, MD, FACS, PLLC dba Neurosurgery and Spine Northwest (NSNW) all insurance payments for medical services rendered to me or to my dependents by NSNW and/or its employees. Furthermore, I authorize NSNW to furnish information to my insurance carriers concerning my illness, injuries, and/or treatments. **I understand and acknowledge that I am fully responsible for any and all amounts not covered by my insurance. All accounts are due within 90 days of service unless prior arrangements have been made.** An annual percentage rate of 18% (1.5% per month) is added to all outstanding accounts after 90 days.
***Initial:* _____**

ASSIGNMENT OF PROCEEDS: I grant and assign to NSNW any and all proceeds from any settlement or court ruling related to the condition and/or injury for which I am being treated. This amount shall not exceed the amount of unpaid services, charges, and/or expenses outstanding to NSNW. ***Initial:* _____**

FINANCIAL ARRANGEMENTS FOR SURGERY: If your treatment includes surgery, NSNW will pre-certify it with your insurance carrier, verify your insurance benefits and obtain your coinsurance and/or deductible. We will estimate your out-of-pocket cost for our surgical services and review this with you before surgery is scheduled. **A deposit for a portion of your out-of-pocket expenses is required prior to your surgery date.** ***Initial:* _____**

COLLECTIONS: If it becomes necessary for NSNW to employ a collection agency and/or attorney following default on your account, all collection fees up to an additional 35% of your outstanding balance and/or reasonable attorney fees may be added to your outstanding account balance. ***Initial:* _____**

RECORDS: I grant NSNW permission to share my medical records with my insurance carrier and other providers as needed to facilitate my treatment. ***Initial:* _____**

PRESCRIPTION REFILLS: I am aware that NSNW does **NOT** authorize new prescriptions or refills prior to 9:00am and after 4:00pm on weekdays and after 4:00pm on Friday through 9:00am on Monday. ***Initial:* _____**

In consideration for services provided by NSNW, I agree to all promises set forth above. I acknowledge my understanding and agree that I am legally responsible for my account and all costs associated with the collection of my account should I default. I agree to pay NSNW at the time of billing for all services rendered and for all costs and losses caused by my failure to pay in a timely manner. I further agree that all promises are freely given with the knowledge that I am granting NSNW substantial rights in the event I fail to pay for services in a timely manner.

PLEASE PRINT Name of Patient or Responsible Party Date

PLEASE SIGN Patient or Responsible Party Date