SURGICAL SPINE ASSOCIATES REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

Other family members seen here:

INSURANCE INFORMATION-PLEASE PRESENT YOUR INSURANCE CARD

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

❑ Highmark	❑ UPMC	❑ Medicare	❑ Medicaid	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

ACCIDENT INFORMATION-COMPLETE ONLY IF VISIT IS DUE TO AN ACCIDENT

Workers Comp/Auto Insurance _____ Address _____ City_____State___Zip_____Phone _____	Date of Accident _____	Claim No. _____	Type of Accident: ❑ Auto ❑ Other ❑ Work Related

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I request that payment of authorized Medicare/other insurance benefits be made on my behalf to Surgical Spine Associates for any services furnished me by physician or supplier. I authorize the release of my medical information to the Centers for Medicare & Medicaid Services and/or my insurance company and its agents, and any information needed to determine this benefit or benefits payable for related services. I am responsible for all charges, regardless of insurance status, as well as copayments and deductibles.

Patient/Guardian signature _____ Date _____

SURGICAL SPINE ASSOCIATES

Eugene A. Bonaroti MD Board Certified Neurosurgeon

www.surgical-spine-associates.com

Telephone: 412.275.0227 Fax: 412.291.2111

Office Locations:

Greensburg
One Aesthetic Way
Greensburg, PA 15601

Scheduling Soon!
Cranberry
One Adams Place
310 Seven Fields Blvd
Seven Fields, PA 16046

Procedure Locations:

Greensburg
One Aesthetic Way
Greensburg, PA 15601

Fox Chapel
107 Gamma Drive
Pittsburgh, PA 15238

South Hills
100 Trich Drive
Washington, PA 15301

New Patient Packet

Welcome to Surgical Spine Associates. We are pleased that you have entrusted us with your health care needs. Please carefully review the packet and answer **all** questions to the best of your knowledge. We appreciate your compliance with completing all forms **prior** to your office visit so that we can develop the best plan of care for you.

How to Best Prepare for Your Appointment:

1. Please arrive **15 minutes** prior to your scheduled appointment time.
2. You must present with a photo I.D. (driver's license, passport, government issued I.D. card) and medical insurance card in order to be seen.
3. Complete all forms included in your New Patient packet **before** your appointment.
4. Bring all imaging studies (MRI, CT scan, X-rays, Nerve Studies EMG/NCV) and radiology reports that pertain to your problem. Please be aware that Surgical Spine Associates is a private practice and cannot access your records from outside facilities without a record request.
5. Wear comfortable clothing. You will be asked to remove your shoes for a Neurologic examination.

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. It will be entered into our electronic health record to ensure the best possible care for you.

Patient's Last Name _____ **First** _____ **MI** _____

Sex ☐ Male ☐ Female **Date of Birth:** _____
Name of Primary Care Physician: _____ **Phone # of PCP:** _____
Name of Referring Physician: _____ **Phone # of referring:** _____
Name of Emergency Contact: _____ **Phone #** _____
Pharmacy Preference (include location): _____ **Phone #** _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? ____Yes ____ No. If yes, please list below:

Name of Medication	Type of Reaction*

Latex Allergy: ☐Yes ☐No IV Contrast Allergy: ☐Yes ☐No

SURGERIES, HOSPITALIZATIONS AND MEDICAL CONDITIONS. If yes, please list:
SURGERIES: _____
_____
_____
_____
HOSPITALIZATIONS: _____
_____
MEDICAL CONDITIONS: _____
_____

RECENT DIAGNOSTIC TESTS, MRI'S, X-RAY'S, EMG'S (Please indicate when/where these were performed):
_____
_____
_____

Have you ever had any problems with **anesthesia** (being numbed or put to sleep)? ☐Yes ☐No
Have you ever been hospitalized for **non-surgical** reasons? ☐Yes ☐No
If yes, list reasons for hospitalizations _____
_____

Surgical Spine Associates

One Aesthetic Way, Greensburg, PA, 15601
Phone: (412) 275-0227 Fax: (412) 291-2111

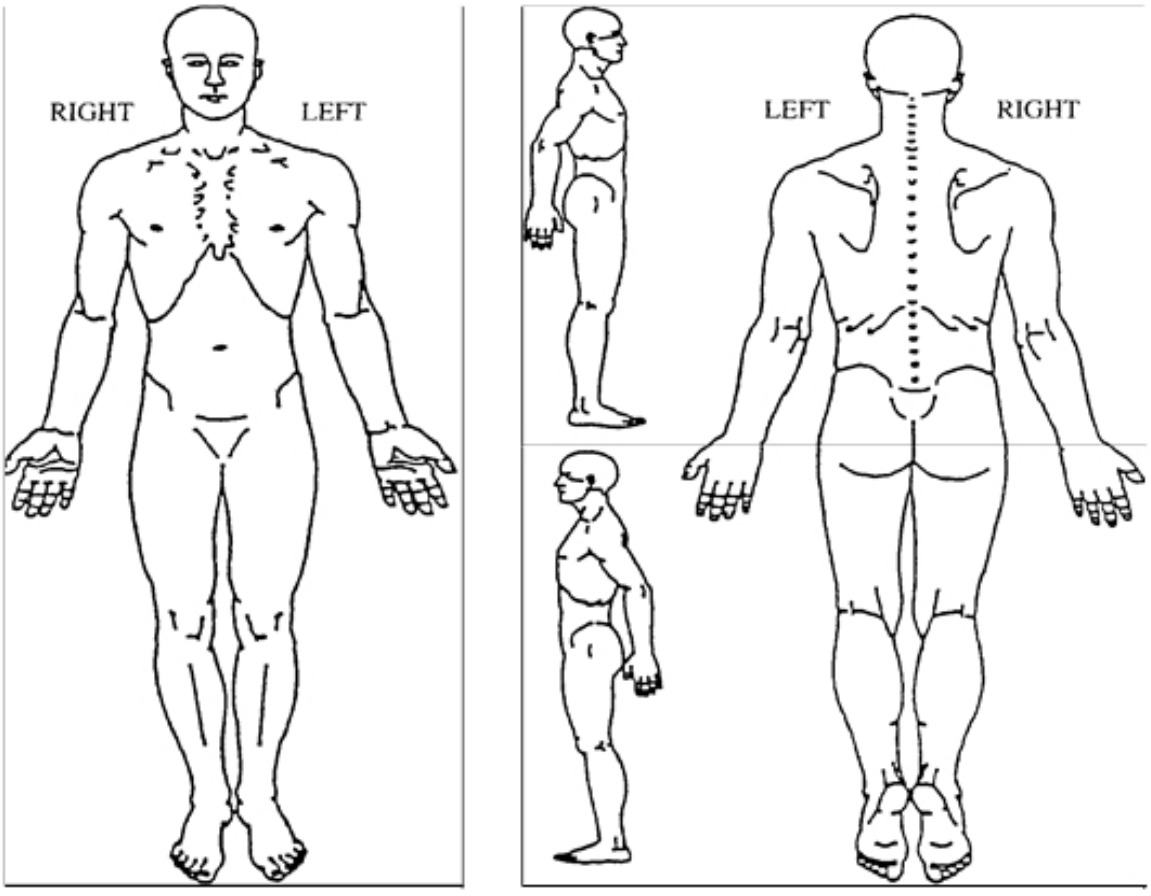
1. Name: _____
   First Middle Initial Last

2. Height _____Weight_____ 3. Date of Birth: _____

Characteristics of Pain

1. What is the main complaint for which you are seeking treatment at Surgical Spine Associates?

2. On the diagram, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.



3. How long have you had the pain problem you are currently experiencing (in months and years)?

4. What caused your current pain?

5. Describe the characteristics of your pain (circle each that describes your pain).

Piercing	Throbbing	Numbing
Stabbing	Cramping	Itching
Shooting	Aching	Tingling
Burning	Stinging	None
Grinding	Squeezing	

6. Please circle all associated symptoms of your pain:

Numbness	Incontinence of bowel	Cool, pale skin
Weakness	Tenderness of affected area	Swelling
Urinary Incontinence	Pain with only a light touch	Redness

Other:_____

Rate your pain by placing an "X" on the line to best describe your pain at its WORST in the past month.

No Pain _____ Pain as bad as it could be

7. Rate your pain by placing an "X" on the line to best describe your pain at its LEAST in the past month.

No Pain _____ Pain as bad as it could be

8. How often do you have pain?
   a. ☐ Constantly (80-100% of the time)
   b. ☐ Nearly constantly (50-80% of the time)
   c. ☐ Intermittently (25-50% of the time)
   d. ☐ Occasionally (less then 25% of the time)

9. What kinds of things make your pain feel better? (example: sitting, sleeping, etc.)

10. What kinds of things make your pain feel worse? (example: standing, lifting, etc.)

SECTION MUST BE COMPLETED.

1. Please indicate which treatments you have tried in the past. Choose the corresponding number indicating the relieving effect on your pain**: PLEASE INCLUDE THE DATE AND DURATION.**

1 – Worsened Pain 2 – No Relief 3 – Partial Relief 4 – Complete Relief

	DATE		DATE		DATE
___Acupuncture	_____	___Hospital Bed Rest	_____	___SI joint injection	_____
___Biofeedback	_____	___Hypnosis	_____	___Spinal Cord Stimulator	_____
___Chiropractor	_____	___Nerve Block	_____	___TENS (Elect Stim)	_____
___Epidural Steroid Inj.	_____	___Physical Therapy	_____	___Traction	_____
___Exercise	_____	___Psychotherapy	_____	___Facet Rhizotomy	_____
___Hot/Cold Tmts	_____	___Surgery	_____	___Pain Pump	_____

If you have had prior neck or back surgery, please indicate the surgery performed:

_____

2. Have any other health care professionals and/or specialists been involved in the evaluation and treatment of your current pain? **If so, please state their name, specialty, and/or their practice name if known.**

Past Medical History

1. Aside from your pain problem, how is your general health? (please check one item)

☐Excellent ☐Minor Health Problems ☐Major Health Problems

2. Have you had any of the following health problems? (please circle all that apply)

Headaches/Migraines	Obstructive Sleep Apnea	Fractures
Neurologic Disorder	Asthma or Wheezing	Blood Disorder
Seizures or Epilepsy	Chronic Cough	Anemia
Transient Ischemic Attack/Stroke	Stomach Ulcer	Blood Clots: Pulmonary/DVT
Chest Pain	History of Polyps	Cancer
High Blood Pressure	Liver Disease/Hepatitis/Cirrhosis	Depression
Heart Attack	Diabetes or High Blood Sugar	Mania
Heart Rhythm Disorder	Thyroid Disease	Suicidal Tendency
Valvular Heart Disease	Kidney Disease	Other:
Pacemaker/AICD	Muscle Disease	
Lung Disease	Arthritis	

Review of Symptoms

Please **circle the symptoms** listed below that you have experienced in the past few months. If you are not having any of these difficulties, please check "No Problems."

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, prior diagnosis of cancer.
Other:_____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, dental problems, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integumentary (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Family Medical History

1. Please list any medical conditions that are present in your family: _____

2. Is there any family history of anesthesia or surgical problems? ☐Yes ☐No

If yes, please describe: _____

Social History

1. Current or previous occupation:_____
2. Present employment status:

   ☐Full Time ☐Unemployed ☐Leave of Absence ☐Student

   ☐Part Time ☐Retired ☐Homemaker
3. Substance intake per day: (Please indicate how often you use or consume the following)
   a. Caffeine (coffee, tea, cola, etc.)_____
   b. Nicotine (Cigarettes, cigar, pipe, smokeless tobacco, etc)_____
4. Your present use of alcoholic beverages is (choose one):

   ☐None ☐Occasionally (less than 1 drink per week) ☐Daily

   ☐Rarely(less than one drink per month) ☐Regularly (drink 2-3 times per week)

   Have you ever made a conscious effort to decrease your drinking? ☐Yes ☐No

   Has anyone ever irritated you by suggesting that you decrease your drinking? ☐Yes ☐No

   Have you ever felt bad about your drinking? ☐Yes ☐No
5. Have you ever used any of the following drugs? Choose all that apply.

   PLEASE INDICATE WHEN LAST USED in the space provided.

   ☐Marijuana _____ ☐Cocaine _____ ☐Other Street Drugs _____

   ☐Amphetamines _____ ☐Heroin _____ ☐ None of these
6. Marital Status (choose one):

   ☐Single ☐Divorced ☐Widowed

   ☐Married ☐Separated ☐Remarried
7. Number of children:_____
8. Present living situation:

   ☐Alone ☐With Children ☐With friend

   ☐With Spouse ☐With Parents ☐With other family members
9. Education (check the highest grade/degree completed):

   ☐Less than 8th grade ☐Some high school ☐Some college ☐Advanced degree

   ☐Completed 8th grade ☐High school graduate ☐College graduate

Signature of Patient: _____ **Date Completed:** _____

If form has been completed by someone *<u>other</u>* than the patient, please print and sign name below:

Name: _____

Signature:_____

Relationship to Patient:_____

Signature of Reviewer: _____ M.D. / NP-C / PA-C

Surgical Spine Associates
Privacy Practices Notice Acknowledgement

Acknowledgement:

I acknowledge that I have received the attached copy of the Surgical Spine Associates Notice of Privacy Practices. I also acknowledge that a copy of the Privacy Practices is available on the internet at www.surgical-spine-associates.com

_____ _____

Patient or Personal Representative Signature | Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

SURGICAL SPINE ASSOCIATES

www.Surgical-Spine-Associates.com

CONSENT TO COMMUNICATE

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	OK to leave voicemail	Ok to leave message with another person	Preferred contact method(s)	Best time to call
Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Send Email				
Email Appt Reminders	☐ Yes ☐ No			
Email Appt Confirmations	☐ Yes ☐ No			
Email Marketing Info	☐ Yes ☐ No			
Send Regular Mail	☐ Yes ☐ No			
Mail to which address: Home Other (please list):				
Send Text Page	☐ Yes ☐ No			
Text Appt Reminders – if so, list cell carrier:				
Text Marketing Info – if so, list cell carrier:				

If its ok to message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Signature: _____ Date: _____

SURGICAL SPINE ASSOCIATES

www.surgical-spine-associates.com
Phone: 412-275-0227 Fax: 412-291-2111

Authorization for USE or DISCLOSURE of Protected Health Information

I hereby authorize: _____ to release information

(Name of facility, entity, or practitioner)

From the record of: _____
Date of Birth: _____
SSN: _____

Release/disclose information to:
Surgical Spine Associates
1 Aesthetic Way
Greensburg, PA 15601

For the specific purpose of:

— Continued Care
__ Legal
__ Personal
__ Insurance
__ Other_____

Dates of treatment (approximate, if known): _____

____ Discharge Summary
____ History/Physical Exam
____ Consults
____ Operative Report
____ PT, OT, SLP Evaluation
____ Progress Notes
____ Lab Tests/Exams
____ Complete Health Record
____ Radiology Reports
____ Photos, videos, images and films
____ Psych Diagnostic Interview
Other _____

NOTE: Psychotherapy notes are excluded from this authorization, as they require a special authorization for use/ disclosure. Behavioral Health, AIDS or HIV, and Drug and Alcohol related information may be documented within the record indicated above and will be released through this authorization unless otherwise indicated.

Name: _____ **Date:** _____

PLEASE BE CERTAIN TO PROVIDE ALL APPROPRIATE SIGNATURES ON PAGE TWO OF THIS FORM. IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING INFORMATION THAT RELATES TO YOUR SIGNING THIS AUTHORIZATION TO USE/DISCLOSE. PLEASE INITIAL WHERE INDICATED.

I **understand** that my authorization is necessary to **obtain or release** my health information and that I may revoke this authorization at any time, **in writing**, except to the extent that Surgical Spine Associates may have already relied upon it in making a use or disclosure. My written revocation will become effective upon Surgical Spine Associates having knowledge of it. If I have provided this authorization to obtain insurance coverage, I may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under my insurance policy. I understand that to revoke this authorization, I must send my written request to Surgical Spine Associates.

This authorization is **limited** to the **purpose**, to the person listed above, and will be in effect for **6 months** after the date of my signature, unless otherwise specified.

_____ This authorization will expire on the following date: _____

_____ Or when the following event occurs _____

I understand that information released by Surgical Spine Associates under this authorization may be re-disclosed by the receiving party, and therefore Surgical Spine Associates and its employees have no responsibility or liability as a result of any redisclosure; as such, the released information is no longer protected by the Privacy Rule.

I understand that Surgical Spine Associates cannot make me sign this authorization as a condition to receive treatment. **I understand** that I am entitled to a completed copy of the Authorization for Use/Disclosure form.

X_____ **X**_____

Date of Patient Signature | Patient Signature

(My signature confirms my understanding of the intended use of this authorization)

_____ _____

Date of Witness Signature | Witness Signature

SURGICAL SPINE ASSOCIATES

SURGICAL SPINE ASSOCIATES

www.surgical-spine-associates.com
Phone: 412-275-0227 Fax: 412-291-2111

PATIENT FINANCIAL POLICY

Surgical Spine Associates (SSA) is committed to providing you with the best possible care and will be happy to discuss questions regarding our policies, fees or your responsibilities at any time. A clear understanding of the "Patient Financial Policy" is important for the entire scope of your care.

All patients must complete our "Patient Information Form" **before** seeing a provider. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance, phone changes etc....)

INSURANCE: As a courtesy we will file your insurance claims. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges. We will supply factual information as necessary. We do provide expert opinions in workers compensation cases as a separate service.

REGARDING HMO'S, PPO'S AND MANAGED CARE PROGRAMS: It is your responsibility to obtain referral forms required by your particular insurance company. We will do our best to remind you when a referral is due, but ultimately you are required to keep track of the referrals on hand. If you present to the office without a current referral you may be rescheduled. If you are seen without the referral you will be responsible for the bill.

COPAYS: You are expected to pay your co pay prior to seeing your provider. If you are unable to pay, you may be required to reschedule your appointment.

REGARDING PATIENTS WITH NO INSURANCE: We will set up payment arrangements for office visits and and for surgical procedures. Therefore if you do not have coverage you will be required to pay for your service in full on the date of the appointment unless prior arrangements have been made. We accept credit cards, money orders and cash payments for your initial evaluation. We will not accept PERSONAL CHECKS for the initial evaluation.

REGARDING MEDICARE: Our providers participate with Medicare. We will file all claims with your Medicare and your supplemental insurance, if applicable. If you do not have a supplemental insurance you will be responsible for the co-insurance and/or deductible amount following the processing of your claim.

MEDICAL RECORDS/FORM COMPLETION: A charge of $20.00 is due before the forms will be completed. (Disability, FMLA, Physician statements, etc.).

SURGICAL SPINE ASSOCIATES

WORKERS COMPENSATION: Our office requires verification of your claim prior to the initial visit. You are also to provide us with any other health insurance coverage in case your workers compensation denies the services. If you do not have health insurance coverage you will be asked to self pay for claims denied by your workers compensation claim.

AUTO LIABILITY: Our office requires verification of the claim prior to the initial visit. You are also required to provide your health insurance coverage. If you do not have health insurance coverage, we will not be able to schedule an appt. In the case that your do have health insurance coverage and it terms you will be responsible to self pay for claims not covered by your auto claim.

COPAYS/DEDUCTIBLES/GUARANTOR RESPONSIBILITY: Our office requires payment in full for any balance not paid by insurance within three months from the date of service. If you are unable to pay our balance in full it is the patient's responsibility to make arrangements with our billing office.

RETURNED CHECKS: There is a $30.00 returned check fee payable in cash or money order.

NO SHOW APPOINTMENTS: You are expected to show for the appointments made for you to adequately provide care. Failure to provide notice (of 24hrs for office visits) that you will not be keeping your appointment may result in a delay

By signing this from I acknowledge that I have read this policy and understand the terms outlined above.

Patient Name (Please print) Patient Signature Date

SURGICAL SPINE ASSOCIATES

Understanding Your Bill

Initial Consultations
If you are evaluated by a physician or physician assistant in one of our offices for an initial consultation, charges incurred cover the time required to obtain a history, your physical examination, review of X-rays, MRIs, and CT scans, review of laboratory studies, review of previous medical records, discussion of your diagnosis and treatment plan, and preparation of a detailed written report which will be sent to your referring physician.

You must be referred by another physician for an initial consultation.

Insurance co-payments are due at the time of your visit.

Office Visit
An "office visit" is exactly the same as a "consultation", except that there is no physician referral. Our practice is a specialty practice that works almost exclusively on a referral basis, so this type of charge is not commonly used.

Follow-up Visits
Subsequent or follow-up visits are typically briefer and have a lower fee than initial consultations.

Insurance co-payments are due at the time of your visit.

Hospital Care
If you receive non-surgical care in a hospital setting, charges apply for initial consultation and for hospital visits on subsequent days, similar to those described above for the outpatient setting.

Insurance co-payments are NOT required for inpatient services.

Surgical Care
If you undergo a surgical procedure with one of our surgeons, charges are typically billed as a **"global fee",** which covers the surgeon's fee for the surgical procedure, as well as all subsequent inpatient and outpatient care for a "global period" of **90 days** after the procedure. (less for some minor procedures).

The fees paid to Surgical Spine Associates specifically DO NOT include fees for the hospital, anesthesia services, operating room time, Xray CT and MRI interpretation by a radiologist, and other hospital charges which are billed separately.

SURGICAL SPINE ASSOCIATES

Understanding Your Bill

Information for Patients with Insurance

Surgical Spine Associates participates with most major insurance plans including Medicare, Medicaid, Highmark, UPMC, Aetna, United Healthcare and others. A complete up-to-date list is maintained on our website www.surgical-spine-associates.com.

(Note: This list is updated periodically. Insurance contracts require renewal on a yearly basis, so check with your insurance carrier if there is any doubt about our participation.)

If Surgical Spine Associates "participates" with your insurance plan, then we have negotiated an agreement with your insurance carrier, and have agreed to accept a predetermined amount for services rendered.

Under the terms of all insurance plan, the patient is responsible for obtaining their own referral.

EVERY INSURANCE PLAN IS DIFFERENT. YOU MUST READ YOUR PLAN CONTRACT TO DETERMINE YOUR SPECIFIC COVERAGE.

Even if you have insurance coverage, you may still be responsible for some or all of the fees for your care:

1. Most insurance plans require small co-payments for initial consults and office visits. Co-payments are due and payable at the time that services are rendered.
2. Pre-approval of services is required by many carriers. Without pre-approval, you may be responsible for fees.
3. Your insurer may only pay a certain percentage of your charges, in which case you will be responsible for the balance.
4. Your insurer may choose not to approve payment for certain services base upon the determination of "medical necessity". In this case, you can appeal the insurers decision. We can support you in your appeal, but your insurer makes the final determination, regardless if your surgeon documents his opinion on the medical necessity of the procedure.
5. Your insurer may place lifetime or annual limits on some care, such as physical therapy services. Your surgeon CANNOT appeal coverage decisions based upon these limits.
6. Your insurer may consider certain procedures "experimental", in which case they may choose not to cover services.
7. Your insurer may choose not to cover services of a physician assistant.

AGAIN: EVERY INSURANCE PLAN IS DIFFERENT. YOU MUST READ YOUR PLAN CONTRACT TO DETERMINE YOUR SPECIFIC COVERAGE.

SURGICAL SPINE ASSOCIATES

Understanding Your Bill

Information for Patients with Nonparticipating Insurance

- If your insurer does not have a contract with Surgical Spine Associates, then services rendered by our physicians are considered "out-of-network".
- Check your plan contract to see if "out-of-network" services are authorized.
- Typically, "out-of-network" services, if covered, are covered at 50-80% of our usual and customary fees. You **will be** responsible for any balance not covered by your insurer.
- If your insurance plan does not allow "out-of-network" services, see information below for patients with no insurance.

Information for Patients covered by Workers Compensation or Auto Insurance

- Surgical Spine Associates DOES participate with many workers compensation and auto insurance plans.
- We require a determination letter from the compensation or auto carrier that you have a valid claim, and that payment is guaranteed.
- Many compensation and auto claims are contested or disputed – therefore, without a letter of coverage, we require coverage from a standard health insurer (such as Blue Cross/Blue Shield) as a "backup" plan.
- If you do not have a letter of determination yet, and have no standard insurance as a "backup", then see the information below for patients with NO insurance.

Information for Patients with NO Insurance

- We will not turn away patients because of a lack of insurance.
- Just like our insured patients, you will need to sign a financial responsibility form.
- Call our billing office to make arrangements for payment – our staff can arrange a payment plan.
- In cases of demonstrated financial need, fees can be reduced or waived.
- In the case of inpatient care or surgery, keep in mind that separate arrangement will need to be made with the hospital which bills separately for its services.

Payment Options

Surgical Spine Associates accepts the following forms of payments:

- Cash, Check, or Money Order
- Visa, Mastercard, Discover, American Express
- Debit Cards