FUNCTION FIRST
SPINE & SPORT

Payment Policy

Function First Spine and Sport, PLLC is committed to providing you with the highest quality of health care at affordable costs. Please read over this document and sign in the space provided below. A copy will be provided for you upon request.

1. CO-PAYMENT AND DEDUCTIBLES. All copayments and deductibles must be paid at the time of service, unless agreed up differently with the Doctor. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment for each visit.
2. COLLECTIONS. We reserve the right to send your account to collections if payment has not been made within 120 days of the date of service. We do allow payment plans.
3. PROOF OF INSURANCE. All patients must complete our patient information form before being seen by the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not the party to contact.
5. NO SHOW FEE. We understand that emergencies happen, but to ensure that all our patients are getting in to see the Doctor in a timely manner, we will be charging a **$25.00** no show fee if no cancellation is received **at least 24 hours** prior to the scheduled appointment.

Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

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Signature of Patient or Responsible Party Date