MINIMALLY INVASIVE BRAIN AND SPINE

Toll Free (800) 323-6427
Local (281) 652-5500
Fax (713) 664-4488

Financial Responsibility Policy

We are committed to providing you with the best Neurosurgical care and are pleased to discuss our professional fees with you at anytime. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

Insurance Coverage-*Minimally Invasive Brain and Spine* is **OUT OF NETWORK** for all insurance plans except Medicare. Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claim. However, the patient is required to provide us with the most accurate and up to dated information about their insurance, and will be responsible for any charges incurred if the information is not correct, updated or benefits are denied by your insurance plan. If recoupment is made by your insurance plan when payment is made on your behalf, you will be responsible for any balance, not covered by the claim payment.

Appointments-24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25.00 may be added to your account.

Referrals-If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit.

Payment/Fees- We accept cash, cashier's check, Master Card, or Visa credit cards for office visits. Unfortunately, we do not accept checks for office visits. Return check fee is $35.00 per occurrence. Medical record fee is $20.00 for the first 50 pages. Completion of any forms (return to work forms, disability forms, insurance forms) by our providers is $20.00 per individual set or $25.00 for FMLA forms, per set. Please allow 10 business days for completion of these documents.

Private Insurance Authorization for Assignment of Benefits/Information release:
I, the undersigned, authorize and direct my insurance carrier(s)including; Medicare, private insurance and any other health/medical plan to issue payment of medical benefits to ***Minimally Invasive Brain and Spine*** or ***Dr. Anthony V. Maioriello*** for any services provided. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning heath care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

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Signature of Patient Date

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Print Name of Patient Witness Signature