Northwest Neurosciences Financial

Thank you for choosing Northwest Neurosciences which includes:

- Northwest Surgery Center- 1110 N 35th Ave, Yakima, WA 98902
- Northwest Spine Center – 1603 116th Ave NE Ste 112, Bellevue, WA 98004
- Northwest Exercise Therapy- 1110 N 35th Ave, Yakima, WA 98902

Our clinics and surgery center are committed to quality medical care. As part of that commitment our providers care for all individuals in a manner that honors and respects their dignity. We are also committed to fiscal responsibility and want to inform you of our billing practices and expectations. The following is a statement of our Financial Policy, we ask you **read** and **sign** prior to any treatment.

_______(Initial) **I am utilizing my OUT OF NETWORK BENEFITS.** All co-pays and deductibles must be paid at the time of service. Patients are eligible for a prompt pay discount. We will bill your insurance as a courtesy and will balance bill you any coinsurance and deductibles that apply. All insurance plans vary, some may not cover certain products or services that are provided as part of our standard of care. You will be billed directly for such items. We will make a reasonable attempt to assist you with insurance claims however it is ultimately your responsibility. Any checks paid to you by your insurance company for services provided by any of the above businesses are expected to be promptly submitted to that business towards the payment of that service.

_______ (Initial) **I am utilizing my PIP benefits through my motor vehicle accident.**

Once your PIP is exhausted we will bill your medical insurance only if you have out of network benefits. If you are utilizing your Out Of Network Benefits please initial the above section as well.

_______ (Initial) **I am awaiting a settlement and have provided a letter of protection signed by my attorney and I in order to hold my bills for a settlement.**

**"Usual, Customary, and Reasonable" fees: Each insurance carrier sets its own 'UCR' rates. They may or may not reflect the average fee charged. Every effort is made to price our services close the average price in our geographical area. Your insurance is a contract between you and the insurance company. If you have complaints regarding your coverage, you will need to take responsibility for following up with your insurance carrier.

I have read the preceding information and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. If my insurance company denies coverage and/or payment for services rendered to me at any of the above locations listed, I assumed the financial responsibility.

____________________ ______________ ____

Date Time Patient/Parent/Legal Representative

__________________________________ ____

Witness If signed by other than patient, indicate relationship