Rev. 07/21/2023

ALIGN SPINE HEALTH CENTER, LLC
8555 16TH STREET, SUITE 800
SILVER SPRING, MD 20910
PHONE: 301-562-0390
FAX: 301-562-0392
EMAIL: info@alignspinecenter.com

Insurance and Payment Agreement:

The doctor's service is provided directly to **you** and not to Insurance Company. However, as a courtesy to our patients, we bill your insurance company for you. If your insurance company does not respond with payment within 45 days of claim submission, we will expect **you** to pay the balance of your bill in full. If you present a card that is not your insurance coverage or that the coverage is not in effect at the time of service, it will be considered fraud and it is punishable by law. Please note the following terms:

- **You are responsible for all co-pays, deductibles and to obtain any referrals required by your insurance carrier. ________**
  Initials
- ***INSURANCE DISCLAIMER:*** **Verification of insurance does not mean a GUARANTEE of PAYMENT. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service. _________**
  Initials
- **Our office will make *a* single reasonable attempt on your behalf to resolve denials of payment from your insurance. However, if *NO* resolve presents, you are responsible for payment of all balances due as indicated by your insurance company. In addition, if our office has to continue to follow up on your behalf to resolve your insurance issue, our office will charge $50.00/hour to your account to compensate for time spent helping the patient resolve payment issues. ________**
  Initials
- **I understand that NO additional services or further treatment be processed or provided unless my account is up to date. _____**
  Initials

The first mailed bill for all balances is due within **five calendar days** of receipt. If we do not receive payment within this time frame, a charge of **thirty dollars** will be added to your account balance. All accounts will be sent to collections or to small claims court after **30 days of non-payment** or if no financial payment arrangements have been made. _______
Intials

If your account is transferred to a collection agency, you agree to reimburse our office the fees of any collection agency, which may be based on a percentage maximum up to 50% of the debt, and all costs (to include court costs) and expenses, including reasonable attorney's fees, we incur in such collection efforts. ________
Initials

Parents or Legal Guardians are responsible for their children's account.

I have read the above notice of my financial responsibilities to Align Spine Health Center, LLC and I agree to the terms above.

____
Print Name

___________________________________ ______________________
Patient, Parent or Legal Guardian's Signature Date