Rev. 12/04/2018

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 if 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 are subject to all terms, conditions, limitations and exclusions of the member's contract at the time of service.** ________ Initials
- **We will make a 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.** ________ Initials

The first mailed bill for all balances is due within **thirty days** of receipt. If we do not receive payment within this time frame, a charge of **fifteen dollars** will be made as a billing charge for the second billing cycle. After two statements, and no payments or payment arrangements have been made with our office your file will be sent to collections. If your account is transferred to a collection agency, you agree to reimburse us the fees of any collection agency, which may be based on a percentage maximum up to 50% of the debt, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.

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