Jonathan T. Paine M.D., P.A.
1305 Valentine St.
Melbourne, Fl 32901

JONATHAN T. PAINE, M.D., P.A. F.A.C.S.

NEUROSURGERY

1305 South Valentine Street
Melbourne. FL 32901
Telephone (321) 727-2468
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Financial Policy

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED – We accept cash, personal checks, Master Card, Visa, and Discover. Returned checks are subject to a service charge of $20.00, and you will lose your privilege to write checks in our office.

CANCELLED APPOINTMENTS – If you need to cancel an appointment, please make every effort to let us know ***AT LEAST 24 HOURS IN ADVANCE.*** Patients will be charged for the office visit after the third missed appointment without notification to the office.

HMO/PPO/MANAGED CARE – Co-payment and deductible must be paid at the time of service. We will file your insurance.

MEDICARE – Your deductible and 20% of the allowable charges are due at the time of service if you do not have a secondary insurance. Since we are Medicare providers, we will file your Medicare.

WORKER'S COMPENSATION – Please have your worker's compensation insurance carrier call us to authorize your appointment. We will file your company's insurance. In the event you fail to execute the claim for Worker's Compensation for this illness or condition, or it is determined by the Worker's Compensation carrier that the illness or condition is not a result of a Worker's Compensation case, you agree to pay our usual and customary fees for services rendered to you.

FINANCIAL AGREEMENT – We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. Please realize however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to all insurance contracts.
2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover (e.g., yearly physicals). Please familiarize yourself with your insurance carrier's benefits and exclusions.
3. Interest is assessed at the rate of 1% per month on balances owing from the patient for more than thirty days.

If it becomes necessary to collect any sum due through an attorney, the patient agrees to pay all reasonable costs of collection, including attorney's fee.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy.

______________________________________ ______________

Signature Date

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PATIENT STATEMENT FOR NON-HMO PATIENTS

I certify that ***I am not a member*** of any Health Maintenance Organization (HMO). If I am enrolled in an HMO and fail to get proper authorization prior to treatment, I agree to take full responsibility for the entire amount of any charge that I may incur.

______________________________ ______________________________
Signature of Patient or Responsible Party Date

PATIENT STATEMENT FOR HMO PATIENTS

I certify that I am a member of the Health Maintenance Organization (HMO) listed below. ***I am aware that it is my responsibility*** to make sure that I have proper authorization in order for services to be covered. I will take full responsibility of any charges which are not covered due to lack of proper authorization or which are considered non-covered services by my HMO.

Name of HMO of which I am currently a member: ______________________________

______________________________ ______________________________
Signature of Patient or Responsible Party Date

I certify that ***I am*** enrolled in a Health Maintenance Organization (HMO) with which this office may or may not have a participating provider agreement. I prefer to be seen without waiting for the necessary authorization. ***I will take full responsibility*** for the entire amount of any charges that I may incur.

______________________________ ______________________________
Signature of Patient or Responsible Party Date