Larry A. Levine, MD | Shawn P. Johnston, MD | Erik A. Olson, DO

Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Our practice firmly believes that a good provider-patient relationship is based on understanding and good communication. The following is a statement of our Financial Policy, which we require that you read and sign before treatment.

Our practice accepts most major insurance companies. All patients must complete our patient registration form and give us the necessary information before seeing a provider. For your initial physician visit we require payment of your deductible, your co-payment, **or a deposit of $100 for patients with auto insurance** (whichever is greater), at the time of service. All return visits with physicians require payment in full at time of service. We accept cash, personal checks, Mastercard, Visa and Debit cards.

You are responsible for any portion of your bill that your insurance carrier denies or does not cover. If your worker's compensation carrier determines that your injury is not work related, they may controvert (deny) your benefits. If your insurance has not paid your account in full within 45 days, you will be asked to pay. *Your insurance coverage is a contract between you and your insurance carrier;* however, we are available to assist you in maximizing your insurance benefits.

Please be aware that few insurance companies attempt to cover all medical costs. Some pay fixed allowances for each procedure while others pay only a percentage of the cost. Many insurance companies use fee schedule derived from providers outside the region and that may not be applicable for the area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

Returned checks and balances older than 30 days are subject to additional collection fees and re billing fees. **Charges may also be made for broken appointments and appointments canceled without 24 hours' advance notice. No-shows and repeated cancellations may limit your ability to make future appointments.**

If you have any questions concerning our financial policy, or if this creates an undue hardship, please contact our practice immediately to discuss special arrangements. **Billing (907-762-6366).**

FINANCIAL POLICY ACKNOWLEDGEMENT

By signing this form, I authorize the release of any medical or other information necessary to process claims. I also authorize payment of medical benefits to ALASKA SPINE INSTITUTE. I understand I am fully responsible for all charges not paid by the insurance company and for co-pays, legal, and collection fees if applicable.

Signature____

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Diplomates American Board of Physical Medicine and Rehabilitation
Diplomates American Board of Electrodiagnostic Medicine
Certified Subspecialty Pain Medicine ABPMR
Diplomates American Board of Pain Medicine
Certified Independent Medical Examiner
+ Doctor of Osteopathic Medicine
Certified Subspecialty Pain Medicine ABMS