MAYFIELD Patient Financial Responsibilities

Thank you for choosing Mayfield Brain & Spine as your healthcare provider. We are committed to your successful treatment, including your pre-treatment planning, clinical services, and the billing/payment process. It is important that you understand your financial responsibilities for the services you receive from Mayfield. The changing healthcare environment puts more responsibility in your hands. We ask that you read, agree to and sign below prior to any treatment.

Insurance: Our providers are In-Network with most major insurance carriers. If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full.

Referrals and Prior Authorization: Many insurance plans require you to obtain a referral from your primary care physician and/or prior authorization before seeing a specialist. You are responsible for obtaining any necessary referrals and authorization before your appointment to receive maximum coverage for our charges. If a referral is not obtained, you may be responsible for the entire visit balance.

Co-payments, Coinsurance, Deductibles: Your co-payment is due at the time of service. If you have a high-deductible plan or coinsurance, we may request a pre-payment to cover your estimated out of pocket amount prior to your date of service. For your convenience, we accept cash, personal checks, Visa, MasterCard, American Express and Discover.

Financial Arrangement for Procedures: If your treatment includes a surgery/procedure, we will obtain a prior authorization for the surgery/procedure with your insurance carrier. We will also verify your insurance benefits and obtain your coinsurance and/or deductible. Using this information, we will estimate your out-of-pocket portion of the charges for our services. The estimated amount will be reviewed with you before surgery is scheduled. A pre-payment request will be made at that time. Actual services and your final out-of-pocket cost obligation may vary from the estimates. Financing may be available with no interest or low interest through CareCredit. More information is available at MayfieldClinic.com in the "For Patients" section or by speaking with our financial counselors at 513-569-5300 option 2.

Self-pay and Out-of-Network: If you do not have insurance coverage or if our providers are out-of-network with your insurance plan, you will be expected to pay at the time of service. Pre-payment may be requested for surgeries or procedures. It is your responsibility to know if our providers are in network with your plan.

Motor Vehicle Accidents (MVA) and Third-Party Billing: We do not bill third party liability insurance (auto, homeowners etc.). It is your responsibility to seek reimbursement from them.

Workers' Compensation: Our providers participate with Ohio and most Kentucky workers' compensation. It is your responsibility to provide the office with employer authorization/contact information regarding a workers' compensation claim.

Your financial responsibility includes an obligation to understand your healthcare insurance plan and benefits. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I acknowledge my understanding and agree that I am legally responsible for my account and all costs associated with the collection of my account. Account balances after insurance will be due within 30 days of patient billing. If Mayfield employs a collection agency or attorney following default, then all collection fees, up to an additional 35% of my outstanding balance and reasonable attorney fees, may be added to the outstanding account balance.

I expressly consent to receiving telephone calls from an automatic telephone dialing system, artificial and/or pre-recorded messages, emails, text messages, or other electronic communication from Mayfield, and/or their contractors, servicers, debt collection agencies, or agents for any reason by using any telephone number, email address, and/or mailing address associated with my account or obtained by such entities. I agree that my consent may only be revoked by sending a written notice to Mayfield or their agents. I agree to arbitrate any claims under the Telephone Consumer Protection Act, and I waive any right/ability to bring a class action against claims, against Mayfield, and/or their contractors, servicers, debt collection agencies, or agents.

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PLEASE PRINT Patient or Responsible Party Date

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PLEASE SIGN Patient or Responsible Party Date