INSIGHT INSTITUTE OF NEUROSURGERY & NEUROSCIENCE (IINN)
JAWAD A. SHAH M.D. P.C.*INSIGHT RADIOLOGISTS PC*INSIGHT PAIN MANAGEMENT
*INSIGHT PHYSICAL THERAPY & NEURO REHAB*INSIGHT CHIROPRACTIC* INSIGHT TOXICOLOGY
ATLANTIS DIAGNOSTIC LABORATORIES
*PRECISION ANESTHESIA*ALLIANCE ANESTHESIA* INSIGHT ANESTHESIA* PRECISION SURGICAL ASSOCIATES
INSIGHT HEALTH & FITNESS CENTER
*INTEGRATED HOSPITAL SPECIALISTS *INSIGHT HEALING CENTER*INSIGHT NEURAL REPAIR CENTER*
INSIGHT ORTHOPEDIC SPECIALISTS

4800 S. Saginaw St.
Flint, MI 48507-2669

Phone: (810) 275-9108
Fax: (810) 963-2881

FINANCIAL POLICY

The following Financial Policy has been set forth by all physicians and other health care providers practicing and/or employed at IINN (hereinafter referred to as "we" or "us"). It is required that the patient and/or responsible party (hereinafter referred to as "you") read and sign this statement prior to any treatment.

SELF PAY
A mandatory payment of 50% is due prior to treatment from all uninsured patients. Monthly payments are required, if needed, until your balance is paid in full. We accept cash, check, money orders and MasterCard, Visa, Discover and American Express card payments.

INSURANCE
We reserve the right to accept or deny assignment of insurance benefits. If we accept assignment of benefits, it is your responsibility to supply our office with a copy of your current insurance card. Please remember that your insurance policy is a contract between you and your insurance company. The balance on your account is your responsibility. Please keep in mind that some, and perhaps all, of the services provided may be non-covered services. Also be aware that some services may not be considered reasonable and/or medically necessary by Medicare or other medical insurance. Regarding insurance plans where we are participating providers, **all co-pays are due at time of service.** In the event that your insurance coverage changes to a plan where we do not participate, please refer to the information in the above paragraph.

WORKER'S COMPENSATION
You must complete and sign a "Worker's Compensation Case" form. It is your responsibility to bring this completed form with you along with all billing information for your account (carrier name and address, contact person, telephone number and claim number). This information must be provided to us prior to treatment. We will not accept a delay in payment due to a worker's compensation dispute and/or litigation. If that is the case, we require a payment plan until a decision is reached. At that time, if the decision is favorable to you, we will attempt to collect payment from them for any outstanding bills that pertain to the treatment of your injury. We will reimburse you for any payments made that your Worker's Comp claim backdates. If the decision is not favorable, we will bill your medical insurance. In the case that you do not have medical insurance or it is past the time limit to file a claim with your medical insurance, you will be held accountable for your full balance.

AUTO/LIABILITY INJURY
If you are being seen due to a liability injury you must provide the following information for billing and verification of payment prior to treatment:

*__Auto Accident__: if you were injured in an auto accident, you must complete and sign an "Auto Case" form and provide us with the name and address of the auto insurance company responsible, your agent/adjuster's name,

telephone number, your claim number and date of accident. You must also state whether the auto insurance is primary to your medical insurance or not and the litigation status of your claim.

*__Slip and fall, etc__.: you will be required to submit the info pertaining to your case i.e. lawyer's contact info, insurance company responsible and their contact info,

For any case, we will not accept a delay in payment due to a claim that is in dispute, under investigation and/or in litigation. If that is the case, we reserve the right to bill you or your medical insurance until a decision is reached. If your medical insurance denies payment due to an open Auto/Liability claim, you will be required to set up a payment plan and make payments until a decision is reached. If the decision is favorable, we will attempt to collect payment from them for any outstanding bills that pertain to the treatment of your injury. We will reimburse you for any payments made that your Auto claim backdates. Your medical insurance will be reimbursed, if they have made payments, once your Auto/Liability insurance has paid. If the decision is not favorable, we will bill your medical insurance if we have not already. In the case that you do not have medical insurance or it is past the time limit to file a claim with your medical insurance, you will be held accountable for your full balance.

MASTER MEDICAL
If your claim is forwarded to Master Medical for review/payment, you are responsible for that portion of your of your bill as Master Medical is patient responsibility. Master Medical will not deal directly with medical offices as they issue any payments directly to the patient. If Master Medical issues a check to you, you agree to either sign the check over to our offices or write us a personal check for the amount owing within 30 days of receiving payment.

MINOR (UNDER 18) PATIENTS
The following parties are responsible for payment of the minor's account balance: the adult accompanying the minor and/or the parents (or guardians of the minor). A minor that is not accompanied by an adult will be denied any non-emergency treatment unless charges for the treatment have been preauthorized.

ASSIGNMENT OF BENEFITS AND RELEASE OF RECORDS
You do hereby assign to us, the medical benefits to which you, or your dependents, are entitled. You also authorize us to furnish to your insurance company all of your patient information, including but not limited to, any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on your account) that is deemed necessary to process this claim. You also authorize us to release any and all patient information and medical records, necessary to collect this debt. Similarly, you authorize us to contact your insurance company, lawyer, or anyone else directly affiliated with your claim in order to collect this debt.

"NO SHOW" APPOINTMENTS FEES
If you are unable to keep your scheduled appointment please be courteous by canceling at least 24 hours in advance. Otherwise, you will be billed a $25 no-show fee for clinic visits. MRI no-shows are billed at $250 each.

DISABILITY PAPERWORK FEES
There is a charge of $25 for each disability document filled out. The paperwork will be completed within 7 business days. Your paperwork will not be released to you, or otherwise appropriate party, until the $25 fee is received.

RETURN CHECK FEES
There is a $20.00 service charge on all return checks that will be your responsibility to pay in addition to the original charges the check was for.

COLLECTION COSTS AND PROCEDURES
If your account becomes delinquent, you agree to pay any additional charges to collect your unpaid bills, including but not limited to, reasonable attorney fees, court costs and collection agency fees. By signing this policy you do acknowledge that we reserve the right to release any patient information and any medical records to our collection agency that are deemed necessary to assist their staff and their attorneys in the collection of this debt.

INSIGHT INSTITUTE OF NEUROSURGERY & NEUROSCIENCE (IINN)
JAWAD A. SHAH M.D. P.C.*INSIGHT RADIOLOGISTS PC*INSIGHT PAIN MANAGEMENT
*INSIGHT PHYSICAL THERAPY & NEURO REHAB*INSIGHT CHIROPRACTIC* INSIGHT TOXICOLOGY
ATLANTIS DIAGNOSTIC LABORATORIES
*PRECISION ANESTHESIA*ALLIANCE ANESTHESIA* INSIGHT ANESTHESIA* PRECISION SURGICAL ASSOCIATES
INSIGHT HEALTH & FITNESS CENTER
*INTEGRATED HOSPITAL SPECIALISTS *INSIGHT HEALING CENTER*INSIGHT NEURAL REPAIR CENTER*
INSIGHT ORTHOPEDIC SPECIALISTS

4800 S. Saginaw St.
Flint, MI 48507-2669

Phone: (810) 275-9108
Fax: (810) 963-2881

FINANCIAL POLICY SIGNATURE PAGE

By signing below you confirm that you read and understood our Financial Policy and that you agree to abide by its contents. Any questions regarding the content can be directed to IINN Billing Dept.

_____ _____
Signature of patient or responsible party Date

_____
Printed Patient Name