Welcome to our pain management practice!

Please review our general and financial policies carefully and contact our office if you have any questions. All necessary forms can be downloaded from our website. These policies are subject to change at the discretion of the practice. **Failure to adhere to these policies may be grounds for discharge from this practice**.

Please note it is the policy of this practice that only patients and staff are allowed in the office and clinical areas unless medically necessary. Children may not be left unattended in the waiting room.

Thank you!

GENERAL AND FINANCIAL POLICY ACKNOWLEDGEMENT OF RECEIPT

In signing this document, I hereby acknowledge that I have received a copy of this **General and Financial Policy**, that I have been provided an opportunity to review the policy and ask questions, and that I agree to adhere to its terms. ***Failure to adhere to the terms of this policy may be grounds for discharge from this practice***. Any signed copy of this document is as valid as the original.

Name of Patient: ____ Date of Birth: ___________________

Signature of Patient: ____ Date: __________________________

Name of Personal Representative (if applicable): _____________________Relationship: ____________________

Signature of Personal Representative: ______________________________ Date: __________________________

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GENERAL POLICY

Welcome to our pain management practice! Please review our general and financial policies carefully and contact our office if you have any questions. Please note it is the policy of this practice that only patients and staff are allowed in the office and clinical areas unless medically necessary. Children may not be left unattended in the waiting room. **Failure to adhere to these policies may be grounds for discharge from this practice.**

OFFICE HOURS: Clinic hours are Mondays through Fridays with the exception of major holidays. Please refer to our website for specific hours of operation.

TO SCHEDULE AN APPOINTMENT: New patients are required to have a physician referral submitted to our office. Upon review and acceptance of your referral, our receptionist will call to schedule an appointment. Existing patients can call our receptionist or request to schedule an appointment through our online patient portal.

PRIOR TO THE INITIAL APPOINTMENT: Before your initial appointment, please **complete** and **sign** the **New Patient Packet** and return the completed documents to our office at least **3 BUSINESS DAYS** in advance of your appointment to give us enough time to process the information. **IF WE HAVE NOT RECEIVED YOUR COMPLETED PACKET**, we may need to reschedule your appointment to a more convenient time. Please also provide our office with copies of any reports from previous tests that have been done for your current pain problem, such as MRI, CT, EMG, Bone Scans, X-Rays, and any other diagnostic testing.

APPOINTMENT POLICY: We ask that you make every effort to arrive **15 MINUTES** before your scheduled appointment. **IF YOU ARE LATE FOR YOUR APPOINTMENT,** we may need to reschedule your appointment to a more convenient time. Please bring with you to each appointment your insurance card, government-issued photo identification card - such as a valid driver's license, and your pain medications in their original bottles.

CANCELLATION POLICY: If you are unable to keep your appointment, please call our office to cancel and reschedule **24 HOURS** before your scheduled appointment. We will gladly make every effort to reschedule your appointment to a more convenient time. **We reserve the right to charge a $50.00 cancellation/no show fee for missed appointments and a $75.00 cancellation/no show fee for missed procedures.**

PRESCRIPTION RENEWAL POLICY: Call our office for a prescription renewal at least **5 BUSINESS DAYS** before you run out of your medication. Have the name of your medication and the name and phone number of your pharmacy available. **If your medication is a Schedule II controlled substance, the written prescription must be picked up from our office.**

PRESCRIPTION PICKUP POLICY: A government-issued photo identification card - such as a valid driver's license - is required when picking up a prescription. It is the policy of this practice that the patient provides us written authorization to have someone else pick up their written prescription on their behalf.

TERMINATION OF THE PATIENT-PHYSICIAN RELATIONSHIP: The patient-physician relationship is based on trust and respect. At times, it may be necessary to terminate that relationship when the trust or respect has been violated. Our office may not provide the patient with further treatment and care when the patient abuses or misuses controlled substance medications or illegal drugs or consistently fails to follow the recommended treatment plan, fails to keep or arrive timely for scheduled appointments, fails to adhere to material office policies, or is threatening or hostile in their attitude or actions towards our providers, staff, or patients. Upon notice of discharge, we will continue to provide emergency medical care for up to 30 days while the patient locates another pain management provider.

CONCERNS AND COMPLAINTS: We value you and want you to be satisfied with the service, care, and treatment that we provide. If you have any concerns or complaints, please let our office manager know as soon as possible.

FINANCIAL POLICY

PAYMENT POLICY: Payment in full is due at the time of service. We accept money orders, cashier's checks, personal checks, debit cards, and all major credit cards. **It is the policy of this practice not to accept cash payments from self-pay patients.**

RETURNED CHECK FEE: A **$35.00 fee** will be charged for any check returned due to insufficient funds.

URINALYSIS FEE: A **$20.00 fee** will be charged for a urinary drug screen (UDS) not covered by insurance or when the deductible has not been met. **It is the policy of this practice to conduct random UDS testing at least twice in a 12-month period and more frequently as indicated**.

PRE-SERVICE DEPOSITS: A **$100.00 deposit** is required for all appointments and procedures not covered by insurance or when the deductible has not been met. Should the appointment or procedure be cancelled outside the terms of our **Cancellation Policy**, the deposit may be applied to the cancellation fee. Any remaining balance will be refunded to the patient or applied to future service dates if the appointment or procedure is not rescheduled.

INSURED PATIENTS' POLICY:

- **YOUR INSURANCE**. Your insurance is a contract between you and your insurance carrier. It is your responsibility to know the benefits and comply with the requirements of your insurance plan. It is also your responsibility to notify us of any changes made to your insurance coverage, such as obtaining new insurance coverage, terminating an existing insurance policy, or changes to existing insurance coverage.
- **NETWORK PROVIDERS**. Our providers are contracted with most major insurance payers, including the Federal Medicare and Medicaid programs. As contracted providers, we are obligated to follow the terms and requirements of our contracts. If we are not contracted with your insurance carrier (a "Non-Participating Insurance Provider"), payment in full is expected at the time of service.
- **INSURANCE VERIFICATION**. We will verify your insurance and benefits eligibility prior to every patient visit. If we are unable to verify your insurance due to incomplete or inaccurate information, payment in full is expected at the time of service, or we may need to reschedule your appointment to a more convenient time.
- **REFERRAL.** If a referral is required by your insurance carrier, it is the policy of this practice not to schedule an initial appointment until that referral has been received from the patient's primary care physician or specialist. Please be advised that with some insurance companies it can take up to **48 HOURS** to obtain a referral authorization. If you do not have the required referral, we may need to reschedule your appointment to a more convenient time.
- **CLAIM SUBMISSION**. As a courtesy to the patient, we will file primary and secondary insurance on your behalf, provided we have complete and accurate insurance information at the time of service.
- **WORKER'S COMPENSATION CLAIM SUBMISSION.** If treatment is due to a work-related injury, as a courtesy to the patient, we will file a worker's compensation claim to the appropriate carrier on your behalf, provided we have complete and accurate insurance information at the time of service.
- **PATIENT RESPONSIBILITY**. At the time of service, it is the policy of this practice to collect co-pays, deductibles, and any non-covered benefits due to policy limits or policy exclusions, as well as failure to comply with your insurance plan requirements. As a courtesy to the patient, our office can estimate the co-insurance patient responsibility based on the services provided and the information received from your insurance company during the verification process.
- **STATEMENT**. Once insurance has made payment, you will receive a statement for any balance owed. It is the policy of this practice that balances must be paid in full **WITHIN 60 DAYS** of the date of the initial statement. It is the responsibility of the patient to inform our office of any address changes. Our office is not responsible for statements, collection notices, or payments lost in mail delivery.

NON-INSURED PATIENTS' POLICY (SELF-PAY):

- **INITIAL VISIT.** The practice will discount its usual and customary initial visit fee to a flat rate **that includes the cost of a urinalysis**. To schedule and secure a new patient appointment, the patient must submit a completed and signed **New Patient Packet**, along with the **$100.00 deposit** at least **3 BUSINESS DAYS** in advance of the appointment. The $100.00 pre-paid deposit will be applied to the cost of the appointment. The balance is due in full at time of service.
- **FOLLOW-UP VISIT**. The practice will discount its usual and customary follow-up appointment fee to a flat rate **that includes the cost of a urinalysis**. Payment is due in full at the time of service.
- **Procedures**. **A $100.00 deposit is required to schedule a procedure.** The $100.00 pre-paid deposit will be applied to the cost of the procedure. The practice will apply a **30% discount** to its usual and customary fees if payment is made in full at the time of the procedure.

COLLECTIONS. If payment in full is not made **WITHIN 60 DAYS** of the date of the initial statement, or satisfactory payment arrangements have not been made with our office, then your account will be in default and may be referred to a collection agency. **SHOULD THE PATIENT'S ACCOUNT BE REFERRED TO A COLLECTION AGENCY FOR NONPAYMENT, YOU AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING CONTINGENCY COLLECTION FEES AND ALL REASONABLE ATTORNEY FEES AND COURT COSTS. SUCH CONTINGENCY FEE WILL BE ADDED TO AND COLLECTED BY THE COLLECTION AGENCY IMMEDIATELY UPON YOUR DEFAULT AND THE REFERRAL OF YOUR ACCOUNT TO SAID COLLECTION AGENCY.**

INSURANCE

Name of Patient: ____ Date of Birth: __________________

INSURANCE INFORMATION

Primary Insurance Company: _____________________________________Phone: _______________________
Plan Name: _________________________________ Group #: __________ID / Policy #: ___________________
Policy Holder's Name: _______________________ Relationship to Insured: ____ SELF ___ SPOUSE ___ CHILD
Date of Birth (month/day/year): _______________ Social Security #:________________Sex: ______________
Secondary Insurance Company: __________________________________Phone: ______________________
Plan Name: _________________________________Group #: __________ ID / Policy #: ___________________
Policy Holder's Name: _______________________ Relationship to Insured: ____ SELF ___ SPOUSE ___ CHILD
Date of Birth (month/day/year): _______________ Social Security #:________________Sex: ______________

WORKERS' COMPENSATION INSURANCE

WORKERS' COMPENSATION (if injured within the scope of employment)
Date of Accident: ____________________________ Place of Accident: _____________________State: ______
Has this accident been reported to the employer? _____YES _____NO If yes, when? __________________
Employer's Name: ____ Phone: _______________________
Claims Address: ____
City: _______________________________________State: _______________________________Zip: _________
Has a report been filed by the employer? _____YES _____NO If yes, when? __________________
Insurance Company: ____ Phone: _______________________
Mailing Address: ____
City: _______________________________________State: _______________________________Zip: _________
Policy #: __________________________________ Claim #: ____

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any medical and/or financial records acquired in the course of examination or treatment by my pain management healthcare providers to its employees and agents; any person or entity which may be liable under contract or by law to the practice or to me, or any person or entity responsible for all or part of the practice's charges, specifically including any insurance company and its employees and agents; any physician treating, consulting, or otherwise performing services for me; and the Centers for Medicare and Medicaid Services, any other governmental or accrediting agency, or their employees or agents.

DIRECT BILLING: I authorize my pain management practice to bill my insurance carrier, including Medicare, Medicaid, private and group insurance, or other health plans, which are or may become payable, including settlements or judgments from the incident for which I am receiving treatment, for services furnished to me by my healthcare providers.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize, request, and assign all medical benefits, including Medicare, Medicaid, private and group insurance, or other health plans, which are or may become payable, including settlements or judgments resulting from the incident for which I am receiving treatment, directly to my pain management practice and its healthcare providers.

In signing this document, I hereby acknowledge that the insurance information I have provided is true and accurate to the best of my knowledge. Falsification of this information may be grounds for discharge from this practice. I also acknowledge that the authorizations stated above are in effect permanently or until canceled by myself in writing. I understand that I may request a copy of this authorization and that any signed copy may be considered as valid as the original.

Signature of Patient / Personal Representative (if applicable): ____________________________________Date: __________________

Name of Patient / Personal Representative (if applicable): ____