FINANCIAL POLICY 2018

We are dedicated to providing the best possible care for you. For that reason, we want you to completely understand our financial policies. Please sign and initial where indicated.

Payment

➔__________ Payment is due at the time of service. We accept all major credit cards.

➔__________ If you have an outstanding balance, the entire balance must be paid prior to your next appointment or you will not be seen.

➔__________ Payment is applied to outstanding balances on the oldest claim. If you pay your coinsurance on the date of service, but later acquire a balance on the older claim, your payment will be applied to that claim first.

Billing & Insurance

➔__________ If we are contracted with your insurance, we will bill your insurance. Keep in mind that we do not know the details of your plan. Please contact your plan for further information.

➔__________ Your insurance policy is a contract between you and the insurance company If we are contracted with your insurance, and you assign your benefits to Pain Solutions, we will file your insurance claim. If your insurance company does not pay Pain Solutions within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

➔__________ We bill all Medicare plans but we do not accept assignment from them. Please refer to our Medicare/Medicare Advantage/Medicaid Notice for more information

➔__________ We do not bill Medigap plans, Secondary Policies or Health Savings Accounts. We will be happy to provide you with a receipt of payment. We do not provide HICFAA forms.

➔__________ We do not accept Medicaid in any form. If you obtain Medicaid benefits, we cannot continue to see you.

➔__________ We are non-participating providers for Medicare. This means you pay in advance and we submit your claim for you. Medicare will reimburse you for everything but your coinsurance. Because we do not accept assignment, your coinsurance is approximately 10% higher than it would be otherwise.

➔__________ If your insurance changes, you must notify us in advance of the change and give us a copy of your new insurance card. If you do not, you will be responsible for all unpaid bills.

➔__________ Our website at nmpainsolutions.com lists our contracted insurances. We are out-of-network for all others. If we are not out-of-network with your insurance, all charges are due at time of service. You must submit your own claims to your insurance. We will provide a receipt of services, but we cannot provide a HICFAA form.

➔__________ Not all insurance plans cover all services. Even if we have a prior authorization with a contracted insurance plan, your insurance plan may decide not to pay. If your insurance plan determines a service “not covered” you are responsible for the complete charge. Payment is due on receipt of statement.

Fines & Penalties

➔__________ On all returned checks, we charge $40.00 plus tax.

➔__________ If you need to cancel a scheduled appointment, you must do so 24 hours in advance. It’s up to you to keep track of your appointments and we do not assume responsibility for notifying you. We charge a $50.00 fee plus tax for failure to give us advance notice of cancellation. This fee must be paid prior to your next appointment.

➔__________ Any unpaid balance after 30 days is considered overdue. All overdue balances are assessed a 1% financing charge per month, 12.68% compounded annually.

➔__________ If you fail to pay your medical bills on a timely basis, we reserve the right to assess a 35 percent collection fee on the total balance due plus sales tax for the use of a collection agency or an attorney.

I have read and understand the practices financial policy, including the $40 plus tax returned check fee, the $50 plus tax no show fee and the collection fees for unpaid balances. I agree to be bound by the terms stated in this policy. I also understand and agree that such terms may be amended by the practice from time to time without explicit notice to myself.

____ ____________________
Signature of Patient of responsible party if a minor — Date

____ ____________________
Printed Name of Patient — Date