PAIN SOLUTIONS 2017+ FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. This is our new policy. ***You must initial where indicated to let us know that you have read and understood our policies.***

Payment

- _____Payment is due at the time of service unless arrangements have been made in advance by your carrier. 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 cannot be seen.

Billing & Insurance

- _____If we are contracted with your insurance, we will bill your insurance. We also bill all Medicare plans. ***WE DO NOT BILL SECONDARY POLICIES OR MEDIGAP PLANS.*** We will be happy to provide you with a receipt of payment for that purpose; we do not provide HICFAA forms.
- _____***We do not accept Medicaid or ANY Medicaid programs. IF YOU HAVE MEDICAID OR LATER ACQUIRE IT, WE WILL NO LONGER BE ABLE TO CONTINUE TO SEE YOU.***
- _____WE ARE NON-PARTICPATING PROVIDERS FOR MEDICARE. ***This means you pay in advance and we submit your claim for you. Medicare will reimburse you. Because we do not participate, your coinsurance will be approximately 10% higher than it would otherwise.***
- _____***If you have a Medicare Advantage Plan, also called a Part C plan, and it does not provide you with out-of-network services, you will not be reimbursed by your plan for medical services provided by Pain Solutions. Check with your plan if you have questions.***
- _____We do not know details about your plan, including your deductible or coinsurance. If you have questions about coverage, call your plan.
- _____Keep in mind that your insurance policy is basically a contract between you and your insurance company. If we are contracted with your insurance, as a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance company directly pay the doctor**. If your insurance company does not pay the practice 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.
- _____If your insurance information 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 medical bills.
- _____IF WE ARE NOT IN NETWORK WITH YOUR INSURANCE, ALL CHARGES ARE DUE AT THE TIME OF SERVICE. YOU MUST SUBMIT YOUR OWN CLAIMS to your insurer.
- _____Our website states the insurance with whom we contract. We are out of network providers for everyone else. If you have a plan that pays only for in-network services, you will not be reimbursed by your insurance company for medical services we provide.
- _____Not all insurance plans cover all services. Even if we have a prior authorization, your insurance company can decide not to pay. If your insurance plan determines a service "not covered," you are responsible for the complete charge. Payment is due upon receipt of a statement.

Fines & Penalties

- _____There is a $40.00 fee on all returned checks**. [$40 + tax = Returned Check Fee**]
- _____**If you need to cancel a scheduled appointment, you must do so twenty-four hours in advance. WHILE WE ATTEMPT TO GIVE REMINDER CALLS, THEY ARE A COURTESY. IT'S UP TO YOU TO KEEP TRACK OF YOUR APPOINTMENTS. We assess a *$45* fee for failure to give us advance notice of cancellation. If you are assessed this fee, it must be paid prior to your next appointment. Furthermore, failure to cancel your appointment in advance may mean that you will no longer be able to see one of our providers. *[$45 + Tax= No Show Fee]***
- _____Any balance that has not been paid off within thirty days is considered overdue. All overdue balances will be assessed a **1% FINANCING CHARGE PER MONTH, 12.68% COMPOUNDED ANNUALLY.**
- _____ If you fail to pay your medical bills on a timely basis, and we are compelled to submit your bills to a collection agency or a lawyer, a **thirty-five percent (35%) collection** fee in addition to the New Mexico state **sales tax** will be added to your bill. (Example: You owe $100. If we submit to a collection agency or a lawyer you will owe $100 x [TAX]% = $100(TAX) x 35% = will be the new sum due.)

I have read and understand the practice's financial policy, including the $40+ tax returned check fee, the $45+ tax no show fee, and the collection fee, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or responsible party, if minor) Date

Printed Name of Patient :_____