Southern Pain
and Spine Specialists

Financial Policy

Medical and Surgical Consent: I, the undersigned, consent to the treatment and procedures which may be performed during this and any further service, and which may include but are not limited to any medical/surgical treatment procedures. I have the right to refuse any treatment and to be informed of the possible medical consequences of refusal. My signature on this document indicates my general consent to be treated. My physician may request that I sign a more specific form relative to any procedure that may be performed.

Release of Information: The physician(s) may disclose any or all parts of these medical records to my insurance carriers(s) and any organizations(s) contractually responsible for purposes of satisfying all charges billed by the physician(s). This includes but is not limited to all claim filings, appeals, and correspondence regarding the charges billed.

Financial Responsibility: I, the undersigned, herby understand and acknowledge that is the policy of this office that payment is made at each visit and I am responsible for payment of all services rendered in my behalf.

Financial Balance Policy: if you have established a balance that is 45 days or older and have not made arrangements to pay it, you will be discharged 30 days from the date the practice notifies you in writing. You must pay any balance owed before you are a patient of the practice again. If the balance is not paid within 30 days, the account will be turned over to collections and reported to the credit bureaus.

Scheduling and No Show Policy: If you are more than five minutes late for your scheduled appointment time, you will be rescheduled to the next available slot. This includes time for filling out the necessary paperwork for your appointment. Example: Your appointment time is 10:00. You arrive and 10 and don't have your paperwork completed, handed in and in the queue until 10:06. In this scenario, you will be rescheduled.

You will be given reminder calls about your appointment and are asked to be here 15-30 minutes early to fill out your paperwork so that the schedule does not get behind. The clock that we go by is at our front desk station. We are endeavoring to stay on schedule and abiding by this policy.

If you do not cancel or reschedule your appointment 24 hours before your appointment time, this will be considered a no show and you will be charged $50.00. If you are sick, please call the office and talk with the medical assistant to determine whether or not this appointment will be rescheduled without a charge. If you do not pay this charge, you will be subject to our Financial Balance Policy described above. Inclement weather falls under our inclement weather policy and no charges will be assessed.

Authorization for Medical Payments: I hereby authorize payment of medical benefits to any physician or supplier for services rendered.

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Insurance Matters: I understand the following concerning insurance:

- We will file your insurance claim; however, we **MUST** have a copy of your insurance card in order to file. At the time of service, you will be responsible for any and all copay, deductibles and co-insurance amounts.
- All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified in writing, you will be responsible for all charges and we will be unable to bill your insurance for any services before the change in notification.
- IN Network Insurance Office Policy: If we are contracted with your insurance company, you will only be responsible for your copays and co-insurance as outlined on your EOB (Explanation of Benefits)
- OUT of Network Insurance Office Policy: If we are not in contract with your insurance company, we will file the insurance on your behalf and accept assignment of the payments. Any balance will be patient responsibility. We are not obligated to write off amounts your insurance company recommends to us.
- Self-Pay Policy: Payment is mandatory at time of visit. You will not be permitted to carry a balance and if a balance remains you will not be able to come back for another visit until satisfactory arrangements have been made.
- As a courtesy, we will file your secondary insurance provided that all insurance information is given at the time of service. If no payment is received from the secondary carrier within 45 days of filing, the unpaid balance becomes patient responsibility. In the event of duplicate payment by the insurance and/or patient, refunds will be sent to the appropriate party as soon as possible.
- All patient balances become due and payable immediately upon your benefits determination or our receipt of the payment or denial notice from your insurance carrier.
- For those patients who are members of an insurance plan that requires a referral, please verify with our front desk staff that current authorization has been received prior to your visit. If we do not have a completed authorization, you will be responsible for your visit.
- The patient, not your office or the insurance company, is responsible for all charges incurred in regarding to all medical/surgical care. We advise you to know your insurance plan and you covered benefits. You will be billed directly for all non-covered services and supplies.

Medicare and/or Medigap Patient: I hereby request that payment of authorized Medicare and/or Medigap Benefits be made on my behalf to Premier Pain Solutions for any services rendered to me. I authorize any holder of medical information about me to release to the health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

Returned Checks: A service charge of $35.00 will be applied to your account for all returned checks. Once a returned check has been received, all future payments must be made with cash, money order or cashier's check.

Responsibility for Services Provided to Minors: The responsibility for payment of services rendered to any dependent children rests with both parents. The responsibility for payment of services rendered to any dependent children of divorced parent rests with both parents as well. Any court ordered responsibility judgment must be determined between the individuals and/or the court system without the inclusion of our office.

_____ Date: _____

Patient Signature (or parent if Patient is a Minor)

_____ Date: _____

Witness