Financial Policy Agreement

Thank you for choosing Pain & Neurology Specialists of Columbia, P.A. for your health care needs. Our primary concern is that you receive the most appropriate treatment to restore and maintain your good health; as with any type of medical care, understanding the financial impact and responsibilities associated with that treatment is also important. **It is important that you read this financial policy agreement before receiving treatment.**

Pain & Neurology Specialists of Columbia, P.A. accepts cash, check, VISA and MasterCard. We will also bill your insurance carrier as a courtesy to you.

To be treated by Pain & Neurology Specialists of Columbia, P.A. you must understand, agree to and initial the provisions set forth below:

__ I understand that if I need to reschedule my appointment, I must call to reschedule at least 24 hours before said appointment. I understand that a $25 fee will be applied to all office visit consultation appointments and a $75 fee will be applied to all office visit procedure appointments not cancelled within a 24 hour period.

__ I understand that my healthcare policy is an agreement between myself and the insurance company. If the insurance company has not paid my bill in full within 60 days of treatment, I agree to contact them to facilitate payment.

__ I understand that insurance copayments and deductibles are due prior to receiving treatment.

__ I agree that any payments sent directly to me are the property of the Provider. I agree to immediately forward to Provider all payments, explanation of benefits and correspondence sent directly to me from all Third Party Payers related to the care rendered by the Provider. I agree that failure to do so will make me responsible for the entire billed charge (unless there are contractual obligations between Provider and Third Party Payer disallowing balance billing).

__ I understand that all treatment charges are my responsibility whether the insurance company pays or not. I understand that not all services are a covered benefit and that I am financially responsible for and agree to pay all charges not paid by my insurance or Third Party Payer within 60 days from time of service. This includes, but is not limited to, deductibles and co-insurance unless there are contractual obligations between Provider and Third Party Payer disallowing balance billing.

__ I understand that I am financially responsible for any increased co-pays, deductibles and non-covered services provided on an out-of-network basis. As a courtesy to our patients, we will obtain any pre-authorization and/or pre-certification required prior to services performed; HOWEVER, I understand that it is my responsibility to ensure these pre- authorization and/or pre-certifications are obtained. This is not the responsibility of my Provider. I also acknowledge that no guarantees have been made by any employee of the Provider, physician or other party about my treatment including whether it will be paid for by any Third Party Payers and/or whether Provider is in or out of my network with my Third Party Payers.

__ I agree to fully cooperate with Providers to assist in their efforts to get claims paid on my behalf. It is my sole responsibility to verify the status of my healthcare benefits directly from my Third Party Payers. It is my sole responsibility to determine what portion of the care rendered by the Provider will be covered by my Third Party Payers and that by receiving said care; I agree to pay any and all charges not paid for by my Third Party Payer within 60 days of receiving said care. I unconditionally guarantee payment of these charges.

__ I agree to promptly notify Provider of any changes in my health insurance plan and/or coverage including changes to my address and/or phone number. I understand that my failure to do so will make me fully responsible for the entire bill as this is not the responsibility of the Provider. In consideration of the services furnished to me, I hereby agree to pay any balance due within thirty (30) days from presentation of my bill and that Providers are not required to honor any limiting notations I make on a payment.

We appreciate your trust in us and thank you for the opportunity to serve your health care needs. If you have any questions or concerns about our payment policies, please ask to speak with a financial counselor either by phone or in person.

ASSIGNMENT AND RELEASE: I authorize payment to be made directly to Pain & Neurology Specialists of Columbia and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my claims. If legal action becomes necessary, I agree to pay all collection fees.

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Responsible Party (Please Print) Date

_____

Responsible Party Signature Witness Initials