

Financial Policy



Thank you for choosing Arizona Pain Specialists! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship. Please carefully review this Financial Policy, initial each section and sign the agreement to indicate your acceptance of its terms.

Payment is Due at the Time of Service

1. All co-payments, deductibles, coinsurance and fees for non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment. If you arrive without your co-payment, we may ask you to reschedule your appointment. We accept cash, checks, debit and credit cards.
2. In the event you need a procedure, we will provide an estimate of your insurance required deductible and co-insurance amounts. Prepayment of this estimate is due at the time the procedure is scheduled or by phone prior to the procedure date. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim.
3. Patient-responsible balances are due when you check in for your appointment.
4. We designate accounts **Self-Pay** under the following circumstances: (1) patient does not have health insurance coverage, (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, or (4) patient does not have a valid insurance referral on file.
5. We request at least **24-hours** advanced notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. You will be charged a fee for each incident according to the Public Fee Schedule. These charges are your personal responsibility and will not be billed to any insurance carrier. Patients who repeatedly “no show” for appointments may be discharged from the practice.

Initial: _____

Proof of Insurance

1. Please bring your insurance card(s) and a valid photo ID with you to each appointment.
2. It is your responsibility to notify the Practice in a timely manner of changes in your health insurance coverage. If the Practice is unable to process your claim within your health insurance carrier’s filing limits, or lack of your response to insurance carrier inquiries due to untimely notice, you will be responsible for all charges.
3. If we are not part of your insurance carrier’s network (out of network) or your insurance carrier pays you directly, you are obligated to forward the payment immediately to the Practice.

Initial: _____

Referrals and Authorization

1. The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier’s plan may have out-of-network charges that have higher deductibles and co-payments, which are your responsibility.

2. If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, if you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance. As a matter of course, the Practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission or by an employee of the practice.
3. The Practice may provide services that your insurance carrier's plan excludes or requires prior authorization. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.

Initial: _____

Billing and Refunds

1. If we must send you a statement, the balance is due in full within 30 days of the statement date.
2. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in adverse reporting to credit bureaus and additional legal action. **The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old.** You agree, in order to service your account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide.
3. You will be charged a fee for returned checks according to the Public Fee Schedule.
4. Our Practice treats patients regardless of financial status. We offer financial assistance in the form of a sliding scale discount based on verifiable household income.
5. If you make an overpayment on your account, we will issue a refund only if there are no other outstanding balances for medical services on your account or any other account(s) with the same financial responsible party.

Initial: _____

Additional Information

1. The Privacy Rule allows you to receive a copy of your personal medical and billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. **Initial:** _____
2. The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. All requests require an office visit. **Initial:** _____
3. By initialing this section, I acknowledge that I have received and reviewed, or have been given opportunity to receive and review, a copy of the Practice's Notice of Privacy Practice. **Initial:** _____
4. By initialing this section, I acknowledge that I have received a copy of the Practice's Public Fee Schedule. **Initial:** _____
5. By initialing this section, I acknowledge that I have received a copy of the Practice's Statement of Patient's Rights. **Initial:** _____

6. By initialing this section, I acknowledge that I have received a copy of the Practice's Advanced Directive Statement. Initial: _____

Practice Code of Conduct

We are pleased to serve you and glad that you chose Arizona Pain as your new pain management provider. We will always strive to provide exceptional care for you.

Reasons that Arizona Pain may ask you to seek health care services elsewhere might include:

- Rude or violent behavior to staff via in-person or telephone - this also applies to your family members and/or friends
- Repeated no shows, cancellations, or continual late arrivals for office visits or procedures
- Refusal to adhere to the plan of care as outlined by your Clinician or to follow health insurance or government guidelines
- Unwarranted requests for disability paperwork

Our goal is to help you. Therefore, we ask that you schedule and keep all follow up appointments, participate in all treatments and diagnostic testing.

Initial: _____

Public Fee Schedule

<u>ITEM</u>	<u>FEE CHARGED</u>
Failure to Cancel your Appointment within 24 hours of the schedule time	\$50.00 per Clinic incident \$100.00 per Procedure or EMG
No Show for your appointment	\$50.00 per Clinic incident \$100.00 per Procedure or EMG
Late Arrivals – if you arrive 15 minutes past your arrival time, <u>and</u> we must reschedule your	\$50.00 per Clinic incident \$100.00 per Procedure or EMG appointment
Return Check Fee	\$30.00 per incident
Completion of Disability Forms	Costs below are per each occurrence: FMLA - \$50.00 each completion Temporary Disabled Parking Permit - \$5.00 Short Term Disability Form - \$25.00

Agreement and Assignment of Benefits

I have read and understand the Financial Policy of Arizona Pain Specialists, PLLC, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to the Practice. I understand that I am financially responsible for all services I receive from the Practice. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

Printed Name: _____

Signed: _____

Date: _____