PARADIGM PAIN AND SPINE CONSULTANTS FINANCIAL RESPONSIBILITIES/APPOINTMENT POLICY

INSURANCE: ALWAYS BRING YOUR CURRENT HEALTH INSURANCE CARD(S) TO YOUR APPOINTMENT. PLEASE NOTIFY OUR STAFF OF ANY CHANGES IN YOUR INSURANCE, HOME ADDRESS, PHONE NUMBERS, EMAIL ADDRESS, ECT. AT THE TIME OF CHECK-IN.
KEEP IN MIND THAT YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL FILE THE INSURANCE CLAIMS FOR YOU, HOWEVER THE ULTIMATE RESPONSIBILITY IS YOURS.
PLEASE BE SURE TO VERIFY THE PARTICIPATION OF THE PHYSICIANS/PROVIDERS AT PARADIGM PAIN AND SPINE CONSULTANTS WITH YOUR INSURANCE PLAN. WE WILL NOT DENY ANY CARE TO A PATIENT DUE TO UNCERTAINTY AS TO THE PARTICIPATION STATUS OF OUR PHYSICIANS/PROVIDERS WITH YOUR INSURANCE PLAN. HOWEVER IF OUR PHYSICIAN/PROVIDER IS NOT PART OF YOUR PLAN, YOUR RESPONSIBILITY FOR FEES MAYBE GREATER. **ULTIMATE RESPONSIBILITY OF FEES IS YOURS.**
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED FOR SERVICES RENDERED TO THE PATIENT LISTED BELOW, MYSELF OR A MINOR UNDER MY CARE AT PARADIGM PAIN AND SPINE CONSULTANTS. I AGREE TO BE RESPONSIBLE FOR ALL APPROPRIATE DEDUCTIBLES, COPAYS, AND COINSURANCE PAYMENT OR DENIED CHARGES. AS WELL AS ANY EXCLUSIONS LISTED IN THE POLICY.

MULTIPLE INSURANCE: IF YOU HAVE MULTIPLE INSURANCE PLANS, IT IS YOUR RESPONSIBILITY TO SEE THAT THEY COORDINATE CORRECTLY.PLEASE MAKE SURE OUR OFFICE HAS THE CORRECT PRIMARY AND SECONDARY INSURANCE IN ORDER. ANY COORDINATION OF BENEFIT (COB) ISSUES ARE THE PATIENT'S RESPONSIBILITY. IF A PATIENT DOES NOT RESOLVE A COB ISSUE BEFORE THE INSURANCE FILLING LIMIT, THE BALANCE WILL BE DUE AND PAYABLE BY THE PATIENT.

REFERRALS/AUTHORIZATIONS: I UNDERSTAND IT IS MY RESPONSIBILITY TO OBTAIN ALL NECESSARY REFERRALS OR AUTHORIZATIONS AS REQUIRED BY MY INSURANCE COMPANY AND PLAN PRIOR TO MY VISIT.

VISIT TYPES: INSURANCE CODING AND VISIT TYPES VARY. WE MUST BILL ACCORDING TO CURRENT CPT GUIDELINES ESTABLISHED BY MEDICARE. IF PROBLEMS ARE DISCUSSED, MEDICATIONS, TESTS ORDERED, OR REFERRALS ARE MADE, THERE MAY BE AN ADDITIONAL CHARGE TO COVER THE ADDITIONAL TIME AND COMPLEXITY OF THE VISIT CHARGE. FOR EXAMPLE: IF YOU ARE HAVING AN EPIDURAL FOR LOW BACK PAIN ,BUT ALSO WANT ADDRESSED YOUR MIGRAINE MEDICATION THIS WOULD BE AN ADDITIONAL CHARGE.

STATEMENTS: IF YOU HAVE A BALANCE ON YOUR ACCOUNT, WE WILL SEND YOU A STATEMENT. YOU WILL BE NOTIFIED OF BALANCES WHEN YOU SCHEDULE AN APPOINTMENT AS WELL.

PAST DUE ACCOUNTS: IF YOUR ACCOUNT BECOMES PAST DUE WE WILL TAKE THE NECESSARY STEPS TO COLLECT THE DEBT. IF WE HAVE TO REFER YOUR ACCOUNT TO AN OUTSIDE AGENCY, YOU AGREE TO PAY ALL OF THE COLLECTION FEES, AND IF NECESSARY, COURT COSTS THAT ARE INCURRED.

APPOINTMENT POLICY:
THERE IS A MINIMUM NOTICE OF 24 HOURS REQUIRED TO CANCEL CONSULTATIONS AND OFFICE EVALUATIONS AND A 48 HOUR MINIMUM TO CANCEL TREATMENT AND PROCEDURES. APPTS MUST BE CANCELED OR R/S ON WEEKDAYS. VOICE MAIL MESSAGE WILL NOT BE PERMITTED. PLEASE BE ADVISED SHOULD YOU NOT GIVE APPROPRIATE NOTICE, OR DO NOT SHOW UP FOR YOUR SCHEDULED VISIT A FEE WILL BE ASSESSED. THE FEE WILL HAVE TO BE PAID PRIOR TO BEING PLACED BACK ON THE SCHEDULE. **A $50.00** FEE ASSESSED FOR CONSULTATIONS/OFFICE EVALUATIONS, AND A **$150** FEE FOR TREATMENTS/PROCEDURES. THIS FEE WILL NOT BE COVERED BY YOUR INSURANCE.

WORKERS' COMPENSATION: If you're covered by a workers' comp claim. It is your responsibility to provide our office with your carrier's information, such as address, phone number, claim number, adjuster and date of injury. It is your responsibility to know and understand your work related injury. Any services that are non-related to the injury, will be billed to your private insurance. It is your responsibility to provide Paradigm Pain and Spine's staff with this information. If your workers compensation case is disputed, if treatment is not authorized, if your case has reach maximum medical improvement (MMI) or your case is settled, it is your responsibility to notify Paradigm Pain and Spine's billing staff.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

PATIENT NAME (PRINT)