Patient Name: _____ DOB: _____

Financial Policy

Thank you for choosing Arizona Pain! We are committed to the success of your medical treatment and care. 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. 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. You are responsible for any unpaid balance after your insurance carrier has processed your claim.

3. 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**.**

4. We request at least **24-hours** advanced notice be given to the office if you will be unable to keep your scheduled appointment. 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, 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 or authorization from your primary care physician. Without an insurance required referral, the insurance company will deny payment for services. If we are unable to obtain the referral prior to your appointment, you will be rescheduled or asked to pay for the visit in advance.

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: _____

Financial Policy

ARIZONA PAIN
WE CHANGE LIVES HERE

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. 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.

4. 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. You may be asked to participate in our Arizona Pain Mobile app. By initialing here, you give Arizona Pain consent to communicate and bill applicable insurances for health screenings taken within the app & assume responsibility for balances not covered by health insurance.

Initial: _____

4. 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, Public Fee Schedule, Statement of Patient's Rights and Advanced Directive Statement.

Initial: _____

Agreement and Assignment of Benefits

I have read and understand the Financial Policy of Arizona Pain Specialists, LLC, 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.

DISCLAIMER: By typing your name below, you are signing this policy electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

_____ _____

Signature (Patient or if minor Signature of parent or guardian) **Date**