DELMARVA
PAIN AND SPINE CENTER

FINANCIAL POLICY & CONSENT

Phone (302) 355-0900
Fax (302) 355-0901
Web delmarvapain.com

You are financially responsible for the medical services you receive at Delmarva Pain and Spine Center, LLC (hereafter referred to as "DPSC"). Please carefully review this Financial Policy, initial each section, and sign the agreement to indicate your acceptance of its terms.

APPOINTMENTS

1. **Copayments, Deductibles, and Coinsurance**. Copayments, deductibles, and coinsurance for clinic visits are due at the time of service, in accordance with the carrier's plan. If you are unable to pay at the time of services, DPSC reserves the right to reschedule your appointment until such time that you are able to make your payment. Deductibles and coinsurances are calculated as an estimate and may be adjusted after treatment based on any changes to services rendered or medications used.

2. **Procedure Prepayment.** DPSC may collect your payment for a procedure at the time the procedure is scheduled. Your prepayment is an estimate of your expected financial responsibility. 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. In the event of overpayment, you may request a refund.

3. **Self-Pay.** If you do not have health insurance, if your health insurance will not pay for services rendered, or if you notify us not to bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule. Payment is due in full at time of service.

4. **Missed Appointments, Late Arrivals, and Cancellation.** Missed appointments and cancellations within 48 hours will result in a $50.00 fee for each incident. The charges are your personal responsibility and will not be charged to your insurance carrier. If you arrive more than 10 minutes late for your appointment, you be may rescheduled to the next available time slot.

INITIAL: _____

INSURANCE PAYMENTS

1. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment, in full, for all medical services provided. Any charges not paid by the carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.

2. **Coverage Changes and Timely Submission.** It is your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which a claim can be submitted on your behalf. If DPSC is unable to process your claim within this period due to incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.

INITIAL: _____

BENEFITS AND AUTHORIZATION

1. **Insurance Plan Participation.** DPSC has specific network agreements with many insurance carriers, but not all. 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 copayments, which you will be responsible for.

2. **Referrals.** Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by DPSC, it is your responsibility to obtain this referral prior to your appointment. Without a referral, you will hold financial responsibility for the visit and subsequent services rendered.

Although, your referring health care provider, and DPSC, are expressly permitted to disclose your Protected Health Information (PHI) for your treatment, under HIPAA, you have the right to request restrictions on the disclosure of your PHI. Under HIPAA, DPSC is not required to agree with you. As a matter of course, DPSC will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission or by an employee of DPSC.

3. **Prior Authorization and Non-Covered Services.** DPSC may provide services that your insurance carrier's plan excludes or requires prior authorization. DPSC, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that service provided to you are covered benefits and authorized by your insurance carrier.

4. **Out-of-Network Payments and Direct Insurer Payments.** You are personally responsible for all charges. If we are not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly for services rendered, you are obligated to forward the payment to DPSC immediately.

INITIAL: _____

ACCOUNT BALANCES AND PAYMENTS

1. **Reassignment of Balances.** If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving and initial statement.

2. **Collection of Unpaid Accounts.** If you have an outstanding balance over 90 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. DPSC reserves the right to refuse treatment to patients with outstanding balances over 30 days old. You agree, in order for us to service our account or to collect any amounts you 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. Methods of contact may include using pre-recorded voice messages or use of an automatic dialing device.

3. **Returned Checks.** You will be charged a service fee of $25.00 for all returned checks.

4. **Refunds.** Refunds for overpayment are processed only after full insurance reimbursement of all medical services has been received. Please submit a written refund request and allow 6 weeks for your request to be processed. Send requests to: Delmarva Pain and Spine Center, LLC, 1 Centurian Dr. Suite 110 Newark, DE 19713

5. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of receipt.

INITIAL: _____

ADDITIONAL FEES

1. **Medication Refill Requests.** All medication refill requests are to be approved by your provider. A fee of $50.00 will be charged for any of the following requests: lost prescriptions, urgent refill/office visit requests (same or next business day); and refills processed after a missed appointment.

INITIAL: _____

2. **Medical Records Requests.** The Privacy Rule allows you to receive a copy of your personal medical records, billing records, and allows DPSC to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. However, if you are unable to come into the office, DPSC will make every accommodation to fulfill your request. A minimum processing fee of $25.00 will apply.

INITIAL: _____

3. **Other Forms.** 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, etc.) assuming the patient is in good standing and has been active with DPSC for 6 months consecutively. Other forms not listed may be considered for completion by DPSC. In these cases, a fee will be determined by the Office Manager. All requests require an office visit.

INITIAL: _____

4. **Notice of Privacy Practices & Statement of Patient's Rights.** A copy of the Notice of Privacy Practices and Statement of Patient's Rights is available upon request from the front desk and can be downloaded on our website: www.delmarvapain.com. By initialing this section, I acknowledge that I have received a copy of the practice's Notice of Privacy Practices and Statement of Patient's Rights.

INITIAL: _____

PRACTICE CODE OF CONDUCT

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

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

- Rude or violent behavior to staff via in-person or telephone encounters. This also applies to your family members and/or friends
- Repeated no shows, cancellations, or continual late arrivals for office visits or procedures as this adversely limits our availability and care for other patients
- Refusal to adhere to the plan of care as outlined by your Clinician or to follow health insurance or government guidelines
- Failure to adhere to the Opioid / Pain Management Agreement
- Unwarranted requests for disability paperwork

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

INITIAL: _____

AGREEMENT AND ASSIGNMENT OF BENEFITS

I have read and understand the Financial Policy and Consent of Delmarva Pain and Spine Center, 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 DPSC. I understand that I am financially responsible for all services I receive from DPSC. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable

Printed Name

X

Patient Signature (or Parent, if Patient is a minor) Date