INTERVENTIONAL
PAIN AND REGENERATIVE
MEDICINE SPECIALISTS

PATIENT POLICY AND WAIVER FORM

PATIENT NAME:_____ DOB:_____
DATE:_____

CREDIT POLICY

Our credit policy is designed to provide a clear understanding that the patient is ultimately responsible for payment of all medical services. Payment of services can be charged to your Visa, Master Card, or Discover credit cards as well as Care Credit. Subach Spinal Solutions is very sensitive to situations in which special payment arrangement may be necessary but must be approved before treatment can occur. All unpaid balances not paid in 30 days (except for qualified insurance claims) may be charged a finance charge of 1% per month. There will be a $35.00 charge assessed for all returned checks. In order for us to service your account or to collect any amounts you owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. In the event that your account is referred to a third-party collection agency and/or collection attorney, you agree that you will be responsible for any and all collection/attorney fees and interest. If costs are expended in order to collect your account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.

HEALTH INSURANCE COVERAGE

We do not participate with most major insurance companies. We do participate with Medicare. As a courtesy to you, we will bill your health insurance, but it is your responsibility to ensure any monies paid by your insurance company is processed. The guarantor and/or patient shall be responsible for any and all costs in connection with collection agency fees and attorney fees which may be required to satisfy the unpaid balance.

PERSONAL PAY

We expect payment at time of service for all office-based charges. If you are having a procedure (surgical or injections), we will bill your health insurance, but payment is expected from you, the patient. In some instances, we will require a down payment or deposit on certain procedures. The office staff will notify you if a deposit is required and how much that deposit will be.

CONSENT TO HIV/HEPATITIS TESTING

In the event a health care provider is directly exposed to your blood or bodily fluids, consent to blood tests to determine the presence or absence of antibodies to the Human Immuno-Deficiency Virus (HIV) and Hepatitis Virus testing is implied by your signature below. You understand that the test results will become a permanent part of your health record. The test results may be released to you or your legally authorized representative and the person who was exposed. In addition, the test results can be obtained by your health insurance carrier or by any person or entity to whom you have given written permission for access to your medical record. In certain circumstances, your records could be subpoenaed for a court order.

ACKNOWLEDGMENT OF POLICIES

I/We, _____, assign to Subach Spinal Solutions all monies entitled to me for the purpose of payment of any unpaid balance resulting from medical treatment received at this facility. I/We further understand that I/We are solely, or together, financially responsible for all charges incurred at this facility but not covered by this assignment, even though represented by an attorney.

PRESCRIPTION MONITORING PROGRAM

To ensure safer prescribing practices and as mandated by law, any provider within Subach Spinal Solutions who is prescribing any controlled substance, is permitted/required to access your records in a central database accessible to healthcare professionals and maintained by the Department of Health Professions to verify your prescription history.

_____ _____
Patient/Guarantor's Signature Date