Midwest Joint Pain Institute,SC
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PLEASE READ CAREFULLY

To All Patients:

Center for Pain Management and Rehabilitation is instituting this policy effective immediately.

These changes in handling our patient accounts must take place due to problems with insurance companies and our involvement with patients' attorneys. CPMR will bill your insurance company. After a patient's insurance pays or denies the claim, the claim becomes patient responsibility. You will be billed for the remainder of unpaid or denied charges. The services provided at CPMR by all providers are ultimately your responsibility. You will be financially responsible for your deductibles, co-insurance or non-covered service. In the event that your health plan determines a service to be **"not payable",** you will be responsible for the complete charge and agree to pay the costs of all services provided. **Any co-pays, balances and self-pays are due at the time of service.** Delayed in payment may result in cancellation of your appointment.

If secondary insurance is involved, we will gladly bill the insurance for you, and the same 90(ninety) day time limit will be enforced. The secondary insurance then will also have ninety days to respond, and then the account balance will become your responsibility.

CPMR does not wait for settlement payment. If you are involved in a motor vehicle accident, worker's compensation case, or liability case, we do not wait for payment for your settlement. In addition, we do not hold responsibility for contacting patient attorneys or case managers in regard to the status of your case. If a patient is involved in legal negotiations, it is solely the patient's responsibility to manage the case and all pertinent issues regarding medical care and payment from settlements.

If CPMR must turn your account over to a collection agency or attorney due to default on such an account, you will be held financially responsible for all charges, including collection fees, attorney fees, court costs, and any other unmentioned fees incurred during the collection of this financial obligation.

Please sign below to acknowledge that you understand and agree to the information above.

Signature_____ **Date**_____

Patient Name_____

Date of Birth_____