CORVALLIS
PAIN MANAGEMENT

PATIENT FINANCIAL & PAYMENT POLICY

This financial policy is an agreement between Corvallis Medical Group, LLC dba Corvallis Pain Management and you, the patient, or responsible party. By signing this agreement form, you are acknowledging that you understand and agree to our financial payment policy.

You must provide us with a current insurance card and billing information. Your insurance policy is a contract between you and the insurance company. It is your responsibility to familiarize yourself with your particular benefit package as you know your policy better than we do. Occasionally, there are discrepancies in what you and the insurance company understand your policy to entail. We base our billing on the information the insurance company provides us.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not automatically guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred. The physician referral and our verification of insurance benefit do not guarantee payment. Do not assume that you will not owe anything if you have more than one insurance policy. If you fail to give us your insurance information or keep your insurance information current, you will be billed for all outstanding charges.

Please initial that you have read and understand the following policies:

_____ RETURNED CHECKS. Returned checks will be charged a $25.00 fee.

_____ BILLING INFORMATION. Past due accounts (i.e., over 90 days) may be subject to a re-billing fee. If no payment is received or your account is not made current, we will initiate collection procedures. Accounts sent to collections will be subject to a $100 billing fee. You will be responsible for all incurred fees related to the collection of your account including attorney, collection service, and court costs.

_____ CANCELLATION AND NO-SHOW POLICY. Should you not be able to make a previously scheduled appointment, a 24-hour notice of cancellation must be provided by phone, email or in person. If notification of cancellation is not received 24 hours before the scheduled appointment, a $30 service charge will be billed directly to the patient for each cancellation. The $30 service charge will be assessed prior to receiving services at the next visit.. Patients who fail to show up for multiple appointments may be discharged from our clinic.

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Please initial next to your payment method (choose one) and sign that you have read, understand, and agree with all of the information in this policy.

_____ **1. CASH PAY**. We will be happy to accept cash pay patients. Payment is due at the time service is rendered and you will receive a receipt. If you have insurance and we are not a preferred provider, you may pay by cash and may be reimbursed by your insurance company if allowed.

_____ **2. PRIVATE HEALTH INSURANCE**. Some insurance plans require authorization and/or a referral from your primary care physician. Most insurance companies have a deductible (i.e., amount paid by the patient before the insurance coverage begins) and either a co-pay (i.e, a set dollar amount per visit) or coinsurance (i.e., a percent of the allowed charges). Deductibles, co-pays, and co-insurance payments are due at the time of service. We will bill you for coinsurance or other balances due after we have been paid by your insurance company or notified of their denial for payment.

_____ **3. MEDICARE**. Corvallis Medical Group, LLC dba Corvallis Pain Management. is a Medicare Preferred Provider. Medicare has an annual deductible of $203.00. Medi-Gap insurance covers the patient's portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always.

_____ **4. WORKER'S COMPENSATION/MOTOR VEHICLE ACCIDENT CLAIMS.** Authorization from your insurance adjuster is required before you can begin treatment. Please provide the name and number of your adjuster as well as your claim number, the date of injury and any other pertinent information. If they deny your claim, you are responsible for the balance. We will be happy to bill your personal health insurance company at that time. If they deny your claim, you will be responsible for the entire balance.

I have reviewed this office policy statement and discussed it with the office staff or my provider. All of my questions have been answered to my satisfaction and I understand all of the information as explained to me. I understand that I am financially responsible for all charges regardless of third-party involvement.I agree to pay any deductible, co-insurance, copay or any service(s) deemed a ``non-covered benefit" by my insurance company. I understand the failure to pay outstanding balances within 90 days will result in submission of my account to an outside collection agency. In addition, failure to pay delinquent account balances may result in termination of care from Corvallis Pain Management.

Patient Signature (or Guardian):_____ Date: _____