CLIFTON OFFICE
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Neil Sinha, M.D.
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08837
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NOTICE TO PATIENTS WITH <u>OUT OF NETWORK BENEFITS</u>
Please be advised that when using you out of network benefits, your insurance company may be mailing payments for our services directly to you (the patient). It is THE PATIENT'S RESPONSIBILTIY to make sure our office receives those payments by promptly endorsing the back of the received check(s) and either mailing or hand delivering the endorsed check(s), along with the explanation of benefits (EOB) to Garden State Pain Management. For your protection, please make copies of all checks for your files before sending them to our office.
I understand that I am utilizing my OUT OF NETWORK BENEFITS. Failure to complete the above in a timely matter is considered noncompliant and no future appointments will be scheduled.
PATIENT'S INITIALS:_____

ASSIGNMENT OF MEDICAL BENEFITS
I authorize my insurance carrier to assign all surgical and/or medical benefits, if applicable, to Garden State Pain Control Center, PA. I also authorize release of medical information necessary to process all medical insurance claims.

PAYMENT POLICY
Co-payments are to be collected at the time services are received; we accept cash or money orders. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office. Returned checks will be subject to #40 collection charges. Any unpaid balances over 90 days are subject to collections via small claims court, attorney, and/or collection agency with applicable collections fees. Collection fees are the responsibility of the patient.

I HAVE READ, UNDERSTOOD AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION ANY PAYMENT POLICIES.
PATIENT
SIGNATURE:_____DATE:_____
_____

I,_____(PLEASE PRINT NAME) give permission to Garden State Pain Control Center, PA to take an identification photograph to be maintained in my medical records. I understand that this picture will be used in a confidential manner related only to my personal care I the above named office.

PATIENT SIGNATURE:_____DATE:_____