PACIFIC PAIN PHYSICIANS

Dr. Michael R. Hullander | Dr. Ralph D. Mozingo
Dr. David C. Pires | Dr. Daniel Roshan

Financial Policy
Patient Financial Agreement

Pacific Pain Physicians is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card. If you are new to the practice, or if your insurance or demographic data has changed, you will be asked to fill out our registration paperwork.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Pacific Pain Physicians will file your insurance claim for you. If the insurance company or information that you designate is incorrect, you will be responsible for payment of the visit. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

We participate or contract with most major insurance carriers, including Medicare, Anthem Blue Cross and Blue Shield, but it is your responsibility to confirm benefits and coverage prior to services provided. We will submit claims to your insurance carrier, but you remain responsible for any charges incurred regardless of your insurance coverage. All unpaid balances will be billed to you as self- pay and are due and payable within 30 days of the statement date. Health insurance is a contract between you and your insurance company. **Your insurance carrier can tell you whether we are contracted with them.** For any insurance plans that we do not participate or contract with, we will bill your insurance under your "out of network benefits". Once we receive payment from your insurance you will be billed a discounted portion of the remaining balance.

It is your responsibility to:

- Know your insurance benefits and coverage.
- Know whether a referral is required.
- Know whether pre-certification for a procedure or surgery is required.
- Notify us of changes to your insurance plan or coverage.

If you have a procedure scheduled in a surgery center or hospital, it is your responsibility to check with the facility to determine your insurance benefits for that facility. Facility fees are paid to the hospital or surgery center and are not determined, billed, or collected by Pacific Pain Physicians. If you have questions after speaking with the facility representative, please talk to your insurance member services before scheduling.

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Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities.

This is a legally binding contract between Pacific Pain Physicians and you. The words, I, me, my, you and your all refer to the patient.

_____ (Initial) I agree to be financially responsible for payment of Pacific Pain Physicians services. Cash, check or credit cards are acceptable forms of payment for these services.

_____ (Initial) Current insurance cards must be presented at every office visit. Pacific Pain Physicians as a courtesy will file your insurance claim. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ (Initial) I agree to give Pacific Pain Physicians my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Pacific Pain Physicians the balance on my account after my insurance claim has been processed.

_____ (Initial) I agree that if my insurance benefit requires an authorization and if the authorization is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

_____ (Initial) I understand that missed and cancelled appointments represent a cost to us, to you, and to other patients of our practice who could have been seen in the time set aside for you. We reserve the right to charge a fee for cancelled or missed appointments. I understand that I will be responsible for any missed or cancelled appointments in which a 24 hour notice was not given. There will be a fee of $25.00 for any missed office visits and $50.00 for any missed office procedures. Multiple missed appointments may result in dismissal from the practice.

_____ (Initial) I understand there will be a $50.00 fee for all returned Checks and will then be required to make payment in cash or by credit card.

_____ (Initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ (Initial) I understand that not all services provided by our office are covered by every plan. Medical care and treatment is dictated solely by medical necessity, and is not based on medical insurance coverage. Any service not covered by your plan will be your responsibility.

_____ (Initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (Initial) If Pacific Pain Physicians has a contract with my insurance company. Pacific Pain Physicians will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-

payments are not made at the time of service, I understand that my appointment may be rescheduled.

_____ (Initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Pacific Pain Physicians my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Pacific Pain Physicians Clinic pursuing any collection means possible.

_____ (Initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs. We will not schedule further routine appointments for you if your account is turned over to a collection agency.

_____ (Initial) If the reason for my appointment is related to a work injury or auto accident, I agree to give Pacific Pain Physicians the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that Pacific Pain Physicians can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.

I have read and I understand Pacific Pain Physicians financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature **Date**

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Pacific Pain Physicians. This is a **DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS**. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me. I authorize Pacific Pain Physicians to deposit checks received on my account when made out in my name. I have read and I understand Pacific Pain Physicians financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature **Date**

_____

Witness Signature

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For Medicare patients: Medicare Patient's Signature – I authorize payment to be made on my behalf to Pacific Pain Physicians for any services provided to me by my provider. I authorize my provider to release to the Health Care Financing Administration and its agents any information needed to determine my benefits.

I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

Patient Name:
(Print)_____

_____ _____

Patient's signature **Date**

_____

Patient's Medicare Number