FINANCIAL POLICY

Co-payments:
All co-payments are to be paid prior to service, in accordance with your health insurance policy. We appreciate your understanding and cooperation with this policy. If you do not have your copay with you at the time of service, you will be asked to reschedule.

Account Balances:
Your balance is due in full upon receipt of your statement. This includes your co-insurance, deductibles and other services not covered by your health insurance. If a balance is not paid in full or payment arrangements have not been made, your account will be sent to an outside collection agency. If your account is in collections, you will not be able to schedule any appointments until your account is paid in full.

Non-Sufficient Fund (NSF) Fee:
There will be a charge of $45 for NSF checks.

Credit Balance:
Credit Balances for patient overpayments will be noted on your account and applied towards future copays and/or other balances due. If you have not scheduled a follow up appointment, a refund check will be mailed to the patient/guardian.

Pre-existing Condition and Precertification:
It is your responsibility to notify us of any pre-existing clause on your policy. It is also your responsibility to know if precertification is required for services and to know if services are a covered benefit under your policy. If your insurance policy has a pre-existing clause, if services are considered investigational, or they are a non-covered benefit, please note that you will be responsible for all charges incurred.

Drug Screening:
The State of Ohio requires that all Pain Clinics monitor their patients via random drug screening. Please note, the random drug screen is not optional if you remain a patient in our pain management clinic and is noted in your Pain Agreement. If a random drug screen is not covered by your insurance, you are responsible for all charges associated with the screening.

Self-Pay Patients:
If you do not have health insurance or if our doctors do not participate with your insurance, payment in full is expected at the time of service prior to being seen.

No Show Appointment Fees:
For all established patient appointments, there will be a $25.00 fee assessed. For all new patient appointments, there will be a $50.00 fee assessed.

We do not accept Motor Vehicle Insurance as a form of payment/insurance.

We are happy to work with you in every way possible to assess individual patient financial situations. If you have any questions, please contact T&W Billing at (330) 436-0860. T&W Billing Office Hours are Tuesday–Friday 10:00 am to 4:00 p.m. Please call with any questions during these times.

Please sign below to signify your receipt and understanding of the above Financial Policy.

Patient Signature: ____ Date:___________

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FINANCIAL POLICY (cont.)

I hereby permit Comprehensive Pain Management Specialists (CPMS) to release any information acquired in the course of my examination or treatment required to process this claim or as required by my insurance carrier for utilization management purposes. If I am insured through military insurance, it may be necessary to release my records to the MTF (Military Treatment Facility) and I also permit any release of records for their purposes.

I hereby agree to pay any and all co-pays, deductibles, amounts over UCR, and/or excluded charges exceeding payments from insurance with whom CPMS does not accept assignment with, and/or any and all co-pays and deductibles with those they do.

I hereby request my insurance carrier to pay on my behalf insurance benefits to CPMS for services rendered. I understand this authorization will be effective until revoked in writing. I understand that if necessary, credit bureau reports may be obtained. CPMS cannot be responsible for collecting my insurance claim nor negotiating a settlement on a disputed claim. CPMS fees are not established by insurance companies. I am responsible for my account.

Patient Signature: ____ Date:____________

I have been given a copy of/had the ability to view the Privacy Statement for Comprehensive Pain Management Specialists. I am aware of my Rights and Responsibilities and the times my Protected Health Information can be shared. I am aware I can file a complaint with the Privacy Officer.

Contact Person:
Coriandra Sammon, Privacy Officer
Comprehensive Pain Management Specialists
2215 E. Waterloo Rd, Suite 313
Akron, OH 44312

Patient Signature: ____ Date:____________

Witness: ____ Date: ___________